

Rhode Island **MEDICAL JOURNAL**

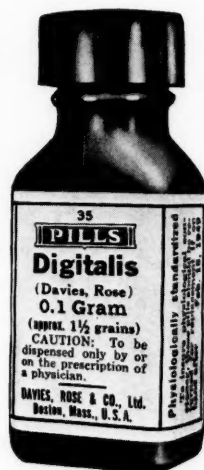


Seventh Annual
CHARLES V. CHAPIN ORATION

"INDUSTRIAL HEALTH"

See Page 483

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The RHODE ISLAND MEDICAL JOURNAL

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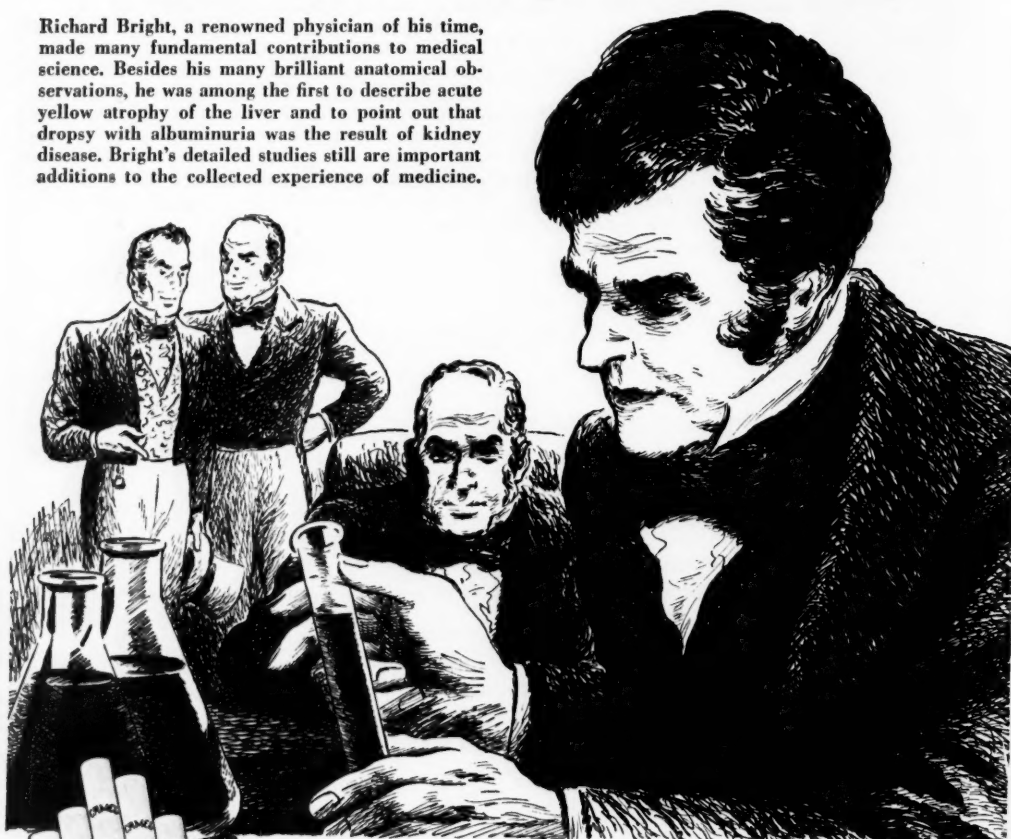
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXI

AUGUST, 1948

No. 8

THE SEVENTH ANNUAL CHARLES V. CHAPIN ORATION*

INDUSTRIAL HEALTH

PHILIP DRINKER

*The Author, Philip Drinker, of Boston, Massachusetts.
Professor of Industrial Hygiene, Harvard School of
Public Health.*

THE NAME of Charles V. Chapin is held in high esteem by all engaged in public health work. It is unusual for a physician to have such a keen understanding of the technical problems in public health engineering as Dr. Chapin possessed. His crusades for improvement in all branches of sanitation benefited us all for he practiced his profession all over the nation. We, at the Harvard School of Public Health, are proud of our small share in this eminent physician's memory. He served for some years on our Faculty and helped us start our School.

I would like to present to you this afternoon a review of some of the industrial health problems which have arisen over the last 50 years. I speak from professional experience over only the last 25. Some of these things have to do with prevention of illness and others are concerned with management and care of the disabled.

Gaseous Impurities in Air

Any job which exposes the worker to adverse conditions is apt to cause disability. The most frequent adverse effect is probably that from breathing air of abnormal composition. The reaction of individuals to various atmospheric impurities varies surprisingly but there is usually no difficulty in setting limits which are safe and defining also those which are lethal. The commonest abnormality in ordinary air is reduction in the normal oxygen pressure. Frequently this change is accompanied by the addition of carbon monoxide. Atmospheres high in nitrogen, and therefore low in oxygen, are found in mines and often on the surface where vegetation has decayed. After fires oxygen concentrations may be low and are

accompanied by excess carbon monoxide. These two, low oxygen and dangerous carbon monoxide, are the leading causes of death from so-called gas poisoning.

Deaths from illuminating gas poisoning in our large cities are always reduced when the carbon monoxide concentration of the gas is reduced. Natural gas contains no carbon monoxide and presents no risk except that of fire. Most of those killed in the Cocoanut Grove disaster in Boston or the Hotel La Salle in Chicago were gassed first with carbon monoxide. Many of the victims in fires are not burned at all. Accounts of the fire raid in Hamburg, and later of Japanese cities indicate that CO gassing caused more casualties than did explosives¹.

All of the major chemical and oil producers are developing new organic solvents of undetermined toxicity. Vapors from organic solvents generally are toxic or inflammable, or both. Naturally, industry prefers to use those which offer the least risk, like acetone and ethyl alcohol, but toxic solvents like carbon disulfide, carbon tetrachloride, and benzol have uses which make them important industrially, even though they are toxic.

A colleague of mine had two patients recently from a large chemical firm with an excellent safety department and an alert management. These men were cleaning the grease off a large piece of machinery and were using a gasoline type of solvent. The safety engineer found the air in the working area was close to the inflammable limit, so ordered the addition of carbon tetrachloride, an excellent grease solvent, to reduce the fire risk. It accomplished the purpose but made one of the men desperately ill with acute liver poisoning². In retrospect we could attend to the degreasing in better fashion but I, for one, would not scold the safety man too much, and neither would anyone else who has seen the results of an explosion in a crowded factory.

* Presented at the 137th Annual Meeting of the Rhode Island Medical Society, at Providence, on May 12, 1948.

continued on next page

Some of the new chemicals pose serious questions as to carcinogenicity, severe dermatitis, and possible toxicity via vapor inhalation. The physician wants to make sure that exposures are safely below the danger point, so he charges the engineer with the job of maintaining safe exposure levels. The engineer promptly asks what is a safe concentration so he can build the equipment to maintain it. Generally the safe limits are not at all precise, and more properly are a range or zone below which man is safe for an ordinary working day. For instance, carbon monoxide concentrations in vehicular tunnels are kept low enough for the tunnel guard, who is on an eight-hour shift in the tunnel.

The discussion as to what range is toxic and what is safe can become acrimonious, depending on the interests represented. I was once called in by a large insurance company whose clerical help in their mimeographing room became sick when the inking apparatus was cleaned with a certain solvent. The firm that sold the solvent objected violently when we set a ventilation figure so low it was cheaper to use a different solvent. It was maintained — and correctly — that the original solvent only made a few people ill, so why should we be so fussy.

Compressed Air Illness

Deep diving and caisson work have been practiced for years. They have always been risky; the pay is high and the hours of work are short. The risks are the immediate ones of drowning, if the air pressure fails, and of compressed air illness, if one is brought too quickly from the high pressure to normal.

The diver is encased in a rubberized suit which is inflated to the pressure of the water surrounding him. The sand hog working in a subaqueous tunnel is protected from water seeping in, by means of compressed air. The diver can descend as rapidly as his buoyancy or the landing stage will allow. The tunnel worker reaches his high pressure by way of an air lock which can be inflated very rapidly. There is no adverse effect on man from these quick inflations, if one's ear passages are clear. But one cannot return quickly to normal pressure after long exposure to high pressures without danger of compressed air illness. Bubbles of nitrogen form in the body tissue and exert pressure on the nerves causing severe pain.

A hundred years ago divers were decompressed gradually and slowly. Then, in 1908, J. S. Haldane³ showed that it was better and vastly quicker to drop the total or absolute pressure to half the original and then go the rest of the way in steps. In 1937 Behnke and Shaw⁴, working at our school, revived and improved upon earlier theories of giving oxy-

gen to divers who were being decompressed. Such oxygen inhalation has proved to be most important in the prevention and treatment of compressed air illness.

In 1925 at the suggestion of J. H. Hildebrand of the Bureau of Mines, Sayers, Yant, and Hildebrand made some trials of mixtures of helium and oxygen for possible use in deep diving⁵. Their results indicated that it might be possible, with helium, to dive to greater depths with faster decompression than was possible with ordinary compressed air. Hildebrand's hope for improvement by using helium was based on the fact that nitrogen, which causes the trouble, diffuses more slowly than does helium. Gases diffuse at rates inversely proportional to their molecular weights which are 28 for nitrogen and 4 for helium. On that basis, hydrogen, with a molecular weight of 2, would be still better, but its inflammability precludes its use in breathing mixtures.

The Navy investigated this possible use of helium and was ready to try it on practical diving tests when the submarine *Squalus* sank in 240 feet of water off Portsmouth, New Hampshire, in 1939. The Navy's best diving team flew to the scene of the disaster, rescued the survivors by means of the Navy's diving bell and then salvaged the vessel after months of superb diving⁶. Their safety record, incidentally, was phenomenal.

It is not beyond the realm of practical engineering for man to drive subaqueous tunnels at greater depth and under greater pressures than any heretofore attempted. It would be possible to operate the tunnel under compressed air, as heretofore. The men, however, would breathe oxy-helium mixtures from breathing bags or tanks carried on the back. The breathing mixture would be replenished from a pipe line within the working area. Such an arrangement would be no more fantastic than some of the things we do in industry today. Remember that working codes now allow a man at high pressures only two shifts of a half hour each. This is his full working day. Anything which will lengthen the possible working period and permit working at greater depths is hopeful for future improvements.

Dust Diseases

In 1920 silicosis was a serious problem in industry. Its significance was not fully appreciated by physicians and it was often ignored or belittled by management. Labor's attitude was rather apathetic because the disease is slow in making itself apparent. Today silicosis is definitely under control, because it is understood. The etiology is well defined and the frequency is gradually lessening.

The improvement is due to dust control and to a full realization of the concomitant effects of pulmonary tuberculosis. Further improvements

will probably parallel reduction in the general incidence of tuberculosis. We have, however, important mining areas in which we have done about all we know how to do, yet we have not eliminated the disease. We claim, nevertheless, that a young man can now become a miner or a stonecutter and go through a normal working life without getting silicosis.

In 1929 the granite producers in New England sponsored a study in our laboratory of dust control in granite cutting. We installed a miniature granite shed with tools operated by a skilled workman supplied by the Union. We soon developed specifications for the control of dust⁷ and have seen them expanded and adopted by both employers and employees.

The drilling and blasting of hard rock in mines has been the major cause of silicosis all over the world. The term, "hard rock", is used designedly, for it implies rock high in quartz, the chief etiological agent in producing silicosis. Today hard rock is drilled wet — a stream of water runs through the shaft of the drill and wets the dust as it is generated. The fact that the water keeps the point of the drill cool and thus helps keep its temper is an added incentive to wet drilling. Also, mines are ventilated under rules which help greatly in supplying the miners with clean air. The combination of wet drilling and ventilation is an effective preventive for silicosis.

1. Aluminum therapy:

It was shown on experimental animals that the inhalation of traces of freshly ground aluminum dust⁸ mixed with quartz greatly lessened the potency of the latter. The results were so promising it was advisable to try such prophylactic treatment on man — an experiment now in progress in several different places. The intent is to prevent the formation of fibrotic nodules in the lung area, rather than to modify any existing lesions — that is, the method is prophylactic and not therapeutic although there was a suggestion of therapy in the original plan. Treatment is not supposed to be given unless reasonable dust control has been installed.

It might be pointed out that no treatment for silicosis has ever been devised and none is likely. The workman is diagnosed as being silicotic when his x-ray picture is clearly abnormal. Often it does not take an expert to make the diagnosis. At that point medical science cannot do much for the man except remove him from further dust exposure and try to prevent him from acquiring tuberculosis. Therefore, if workmen demand that this aluminum prophylaxis be thoroughly explored their attitude is understandable.

2. Shaver's disease:

A brand new industrial disease was described recently by Shaver and Riddell⁹, who observed spontaneous pneumothoraces in men exposed to fumes from high temperature electric furnaces in which aluminum oxide, as the mineral bauxite, was melted and fused with coke. The resulting fume consisted essentially in alumina, Al_2O_3 and silica, SiO_2 in the approximate proportions of 50 to 40¹⁰. The plant they described had been running for some years but, during the war, was pressed hard to turn out more material so that the ventilation was overtaxed and became inadequate. Until then no trouble had been experienced, or at least it had passed unnoticed.

The etiology of the disease, appropriately named after Shaver, who first described it, is undetermined and may easily remain so as it is reported that plant changes have eliminated the air pollution. The condition produced was serious to 35 workers and fatal to 7 out of 344 individuals exposed. The size of the particles in the fume was of the order of a fraction of a micron, measurable only by electron microscope. We have no data at all on the effects of breathing such finely divided fume particles. All of the past exposures to silica have been from dusts created by processes such as stone cutting, rock drilling or crushing. Alumina, Al_2O_3 , has never been known to cause anything remotely resembling the condition described.

Gardner¹¹ showed that quartz dust above 3 microns was unlikely to cause any fibrosis. We¹² extended this study down to 0.6 micron dusts and found the potency to increase markedly as particle size decreased. Hatch and Kindsvatter¹³ exposed animals to ground silica dust averaging 0.18 microns in size and produced even more severe lesions, showing that maximum potency had not been reached.

Recently there has been introduced commercially a number of different kinds of finely divided silica made by chemical processes such that the ultimate particle size is still smaller. The results of potency tests have yet to be published. Until they are, industry probably will look upon this silica as very toxic and handle it with proper precautions. There seems to be unanimity in expecting considerable industrial use for it.

3. Beryllium poisoning:

In 1943 Hyslop¹⁴ and others published a paper indicating that the metal beryllium, of itself, was not toxic and that toxic effects from use of beryllium in its various compounds or alloys was due to acid radicals in beryllium compounds or to hydrolysis of the beryllium salts. Unfortunately this optimistic forecast was expanded somewhat beyond the implications of the authors, which were none too

continued on next page

clear, and beryllium compounds were used in the fluorescent lamp industry with no special precautions. A series of extremely severe poisonings and numerous deaths occurred¹⁵ and others are now being reported from plants processing beryllium ores.

The largest use for beryllium is by atomic energy plants, as it serves a purpose in the atomic piles for which there is no present substitute. These plants and some of their sub-contractors for the Atomic Energy Commission have had fatalities and serious beryllium poisonings from processing beryllium ore and from machining, grinding and polishing to pure metal.

Beryllium is the lightest metal known and imparts to copper properties which go to make up a spring of great strength and of considerable industrial promise. It is also used in alloys for non-sparking tools. Companies engaged in making such alloys claimed that there had been no ill effects from the beryllium so used but this claim has been refuted, as typical fatal poisonings have been reported.

The disabilities which occurred in the fluorescent lamp industry in our own state of Massachusetts caused what Hardy and Tabershaw¹⁵ described as a delayed chemical pneumonitis. Some of the patients died and, at autopsy, showed lung and liver lesions which pathologists considered to bear resemblance to sarcoid for which the condition was at first mistaken.

At the present time the etiology of these poisonings is still obscure but there is no question at all that beryllium compounds must be handled with extreme caution.

4. Lead poisoning:

Another classical industrial disease, lead poisoning, is becoming a rarity. It has been shown that it can generally be forecast, and thus prevented, by routine urinalyses. Normal urinary lead is below 0.2 milligrams per liter¹⁶ so that consistent excretion of lead much in excess of the normal is viewed with suspicion. The patient can generally be moved to a less dusty job before his lead absorption reaches clinically significant levels.

This optimistic state of affairs does not mean we no longer have lead poisoning. It means that we can and do prevent it, yet we continue to use lead in vast quantities.

5. Metal fume fever:

Another industrial disease, metal fume fever, poses some unsolved problems which are reminiscent of the complexities introduced by the exposure to submicroscopic fume particles in Shaver's disease. It has been known for many years that the breathing of dense clouds of freshly formed

zinc oxide caused a transient febrile reaction which is incapacitating for about a day.¹⁷ The body temperature can rise to as much as 104°F. and is accompanied by a leukocytosis which persists for some hours after the temperature has subsided to normal. While the white cell count remains high, one enjoys a resistance to a second attack of the fever and can inhale, with impunity, an amount of zinc oxide which ordinarily causes a sharp temperature rise.¹⁸ Metals other than zinc can be burned to the oxides which, in turn, can produce reactions somewhat like those from zinc oxide, but the reactions may be of very different severity. For example, freshly burned magnesium oxide¹⁹ has negligible effect, while cadmium oxide can produce a fatal reaction.²⁰

But one fails to induce metal fume fever from zinc oxide taken from the commercial package and blown into the air. Similarly, cadmium oxide fumes from freshly burned cadmium are dangerous, yet men handle safely this identical cadmium oxide once it has been collected.²¹ There is no chemical difference between the freshly formed zinc oxide and that which is taken from the chemical package. The freshly formed oxide disperses nicely in air and forms a cloud which disseminates uniformly throughout any confined space. The material from a package flocs and is hard to disperse, save in liquid media such as a paint vehicle. Men who tend zinc furnaces know perfectly well what metal fume fever is and do not pay much attention to it. They know how to avoid it and know its effects are not cumulative. Those who handle the collected powder seemingly do not get metal fume fever although they breathe concentrations in excess of those breathed by the furnace men.

Industrial Uses of X-rays and of Atomic Energy

The atomic era has ushered in a new set of public health problems which are very troublesome. It is common practice to take roentgenograms by radium or by x-ray of metallic castings in order to detect defects. Fluoroscopic inspection of parts passing along on a belt may be required in manufacturing specifications. Adequate safety rules have been developed, but intelligent enforcement is far from perfect.

Fluoroscopes are used by shoe stores under conditions which roentgenologists would scarcely approve. You may remember that in 1943 we had a disastrous series of x-ray burns in a shipyard dispensary when unauthorized persons repeatedly stuck their hands into a fluoroscope for the amusement of themselves and their friends.

The estimation and control of exposure to radioactive substances, called health physics, is now well organized. We hope it belongs properly to the field of industrial hygiene. The impetus for the rapid

development of this science was, of course, the atomic bomb project. The scientists who planned and carried out the construction and operation of our atomic energy plants had a very full appreciation of the serious health risks involved and took more than what industry calls legally *all reasonable precautions*. With other engineers, I had the privilege of visiting these plants recently and studying their records with view to helping them plan their peace-time control of the health risks resulting from nuclear fission. We were greatly impressed by the fact that their large plants at Oak Ridge, Tennessee and Hanford, Washington, attained a remarkable safety record. Their industrial medical and their safety setups were elaborate and expensive, but their results were so much better than anything we, supposedly experts in this field, had expected to see, it made us revise our ideas on preventive work. You will appreciate the fact that the individual companies, like DuPont, Eastman, and Stone and Webster took the contracts to build and operate these plants with the proviso that they be allowed to do what they thought was reasonable to make conditions safe. Admittedly, expense was not spared, and some money was wasted, but the proof that nuclear energy can be utilized safely was established.

Unsolved are some of the pollution problems which you can find outlined in the Smyth²² and Baruch²³ reports, both of which should be required reading. Some of the gases from the stacks carry radioactive gases and particulate impurities. Water from the laundries which clean "hot clothing" becomes contaminated. Machinery, tool steel, and building materials become too hot to handle. What is to be done with these wastes? It is no secret that atomic power will be with us before so many years, so that a practical solution of these difficulties cannot be postponed.

Labor Relations and Health

There is no question at all that establishment of the Coal Miners Welfare Fund by John L. Lewis raised the preplacement and the checkup physical examinations to the level of respectability in union circles. In a large smelter with which I am connected, the striking workmen arranged in advance with management for the men to leave the picket line to enter the plant and have their routine medical examination. This occurred in 1947 on the west coast, not far from a shipbuilding area, where in 1944, the Maritime Commission, Navy, and Public Health Service, acting as a team, were prevented by the dominating union from giving checkup examinations and chest x-rays to a group of welders. I was in charge of the shipyard health work and that experience rankled sorely, for we had been promised cooperation by union headquarters in Washington. It turned out that the local union

official responsible for keeping us out had witnessed a stupid abuse of x-ray examination in a plant in Massachusetts some years before and he had not forgotten the event.

The establishment of workers' clinics, as by the Union Health Center of the garment workers in New York and the Labor Health Institute in St. Louis, has done much to show the workman what he has to gain from good medicine and good public health practice. Such clinics are prepaid medical schemes, but they are logical; they are economically sound, and they work.

Industry is greatly concerned with absenteeism. It wants the man to have medical advice that will get him back to work and on the payroll. The illnesses and accidents which come into a busy industrial clinic in a large factory are not much different from those which come to the Out-Patient Department of a busy city hospital. Why not handle them in exactly the same way the hospital would, by treating them right there and referring to specialists those you would refer in ordinary practice? This means the industrial doctor becomes a general practitioner and steals some of the patients from the local general practitioner.

When a worker comes to the plant physician and asks him if he won't call at his house to see his wife or child, management knows that the physician has the respect of the worker. This is precisely what is needed. Management would like the doctor to be completely free to practice medicine and not to bother whether the patient's condition is the result of his job or not. Industry needs good medical practice and it can offer some attractive inducements. It will pay decent salaries and make conditions pleasant. To the physician who looks askance at industrial practice we would point out that we have about 60,000,000 workers in the United States, and some 10 or 15 million of them came out of the armed forces where public medical care was practiced very effectively. It is unlikely that these men and women will tolerate anything less good than they had in the Services.

I doubt if there is a good hospital in the country, certainly no teaching hospital, that does not need new income and need it badly. Industry wants good medicine and does not want it free. There is nothing but an outmoded tradition which prevents hospitals and clinics from approaching industry and offering to help in the management of their medical and surgical problems. Industry would expect to pay for such service. You would get an especially favorable reaction from insurance companies and compensation boards if your hospitals would offer to contract to help them with their rehabilitation of the injured and of the mal-adjusted worker.

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Workmen's Compensation and Health

It is a regrettable fact that the most effective stimulus which one can apply to the employer who refuses to recognize a health or accident hazard is an expensive damage suit. Admittedly, litigation is not a good way to settle an argument, but a lawsuit undeniably has a salutary effect.

In most states industrial accidents and diseases are compensable and the suit is heard before a commission and not before a judge and jury. This means that eloquence and oratory give place to a terse presentation of the facts, which include the clinical and surgical findings, as well as a good case history—an account of the working conditions. By and large the employer does better under the compensation law than at common law, and damages can be guessed pretty accurately in the event of an adverse decision. The net result is that the worker gets his award promptly and without expensive lawyers' fees if his claim has any merit at all.

There are several industrially important states, such as Ohio and Washington, where compensation insurance is a state monopoly. Others, like New York and California, allow private companies to compete with the state funds. Still others, like Massachusetts, have no state fund and all compensation insurance is carried by private insurance companies, or the employers are self insured, with state license.

From my own experience in dealing with these problems, I believe the competition engendered by having the state fund and private companies compete is a good thing—if the competition is kept on a fair basis. State monopolies become too powerful and the people suffer, just as they suffer from the improper abuse of power by any other group. Also, the monopolistic funds, in my opinion, can become bureaucratic, inefficient and expensive, for there is no one forcing them to keep down their costs.

In compensation suits industry is often inflicted with testimony from reputable doctors who are completely without industrial experience. A statement from a patient that he works in such and such a plant is enough to elicit a diagnosis so colored that the case can be construed only as one of industrial poisoning. The doctor cannot very well be expected to go and see what all his patients do, so he guesses at the job from the patient's description of it. This kind of thing got badly out of hand in about 1930 when there were a great many suits, all over the east, for silicosis. Some of the country's most eminent radiologists, like Pancoast in Philadelphia, then got their colleagues to agree that a reliable history of exposure to free silica dust was essential to the making of a diagnosis of silicosis.

Today no good radiologist will venture such a diagnosis without a history of heavy exposure to silica dust. We, who work with the industry, would be grateful if all doctors would be as careful in getting the workman's history.

If a workman develops a hernia he is apt to go before the Compensation Board and state that he first became aware of his injury while performing some task in the factory at some definite time. If he does he is virtually certain to be paid compensation for his loss of time and for the cost of the surgery necessary. This implies that hernias are solely industrial in origin—something nobody thinks is true.

If an employee becomes partly incapacitated from heart trouble, is given an easy job such as operating an elevator, and dies one night while at home it may or may not be considered occupational—the decision is unpredictable. But if the cardiac patient dies while he is on the plant premises most state Commissions would hold that the death should be charged to industry.

Such decisions are not good for labor relations and they create a distrust of medicine in the eyes of both employer and employee. We wish good physicians would not be so reluctant to go to court and testify in these compensation cases. The ordeal is not a severe one, the reputable physician commands respect, and his considered opinion is heeded.

Many of our states have occupational disease laws under which compensation is limited to a schedule of industrial diseases like lead poisoning or silicosis. When something new comes along like Shaver's disease or beryllium poisoning, redress has to come via common law. There is nothing worse for labor relations than such needless damage suits. Defeat rankles, no matter who is the loser. In its wisdom the Supreme Court of Massachusetts declared that silicosis should be compensated as an accident because it is traumatic. This decision has saved us a lot of trouble, as any new industrial disease can be handled very satisfactorily by the State Industrial Accident Board. Nobody but the etymological purists care two cents whether silicosis is traumatic or not—an amusing state of affairs, but not an unjust one.

Wisconsin compensates for any disease arising out of, or in the course of employment, but most states stick to the scheduled list of diseases and do not even make provision for periodic revision of the list. Texas is one of the last to pass such a scheduled law, and it will be interesting to see what our own New England state of Vermont passes in the next session of the legislature when the matter is to come up.

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CONTINUOUS LUMBAR PERIDURAL ANESTHESIA IN OBSTETRICS*

HOWARD W. UMSTEAD, M.D. AND WALTER J. DUFRESNE, M.D.

The Authors. *Howard W. Umstead, M.D., of Pawtucket, Chief, Anesthesia Department, Memorial Hospital. Walter J. Dufresne, M.D., of Pawtucket, Senior Surgeon, Obstetrical Department, Memorial Hospital; Chief Obstetrician, Notre Dame Hospital; Courtesy Staff, Providence Lying-In Hospital.*

SINCE THE DISCOVERY of continuous caudal anesthesia in 1942 by Hingson, Edwards, and Southworth, a rapidly increasing number of obstetricians and anesthesiologists have become interested in its application for obstetrical anesthesia. An extensive report this year by Hingson, Edwards, Lull, Whitacre, and Franklin,¹ reveals that 264 papers have been published in medical literature recording results in more than 600,000 cases. In this same report, figures are presented which indicate a reduction in stillbirths and in neonatal mortality when patients are delivered with continuous caudal anesthesia. Other workers^{2, 3, 4}, employing spinal or caudal methods of anesthesia have also been impressed with the well being of the baby at delivery. This feature alone, the possibility of saving infants, will serve as a stimulus for a more extensive use of continuous caudal anesthesia throughout the country. Furthermore, it offers a dramatic and complete relief of obstetrical pain in contrast to the varying results frequently seen with the more common schemes of obstetrical anesthesia.

On the other side of the ledger are certain hazards and disturbances of labor that are associated with continuous caudal anesthesia. Serious circulatory embarrassment may result from accidental injection into the subarachnoid space, too high a level of anesthesia, and in the occasional patient with a very labile blood pressure. The situation can usually be corrected by a prompt institution of supportive measures but fatalities are on record. Another very disturbing complication is infection of the sacral canal. Ellis and Sheffrey,⁵ in an article dealing with mortality under continuous caudal anesthesia, give a brief account of one such case which caused the death of the patient. In addition, one must consider the advisability of frequent forceps delivery and an occasional case of arrested

labor. The present status of continuous caudal anesthesia is certainly open to argument, and strong support can be found for both sides of the issue.

Recently, one of us had the pleasure of hearing Dr. Manuel Curbelo⁶ of Havana, Cuba, describe a technique for the continuous administration of lumbar peridural anesthesia by means of a ureteral catheter. He discussed the procedure in relation to abdominal surgery, and a report of his work is due to appear in one of the anesthesia journals this year. Dr. Curbelo's method appeared very tempting as a more suitable form of obstetrical anesthesia for two reasons: first, the needle puncture is made in the relatively clean lumbar region rather than at the highly contaminated sacral area; and, secondly, it seemed probable that satisfactory anesthesia could be established with smaller amounts of the same anesthetic solution.

A few sentences will explain the relationship between lumbar peridural anesthesia and caudal anesthesia. In the caudal technique, a needle is passed through the sacral hiatus at the lower end of the spine and advanced into the sacral canal. An anesthetic solution injected in sufficient volume not only fills the sacral canal but also extends up into the lumbar and finally the thoracic region of the spinal column. This solution is outside of the dura and may be described as peridural in its distribution. It has been demonstrated by Dogliotti⁷ and others that a space or area of very loose tissue surrounds the dura and even extends along the spinal nerves beyond the confines of the spinal column. In the case of lumbar peridural anesthesia, the difference in technique is simply one of approach to the peridural space. The needle is inserted between the spinous processes of two lumbar vertebrae and advanced until its tip lies within the peridural tissue or space. To institute a continuous technique it is necessary to use a 16 gauge Huber point needle for the puncture, pass a ureteral catheter into the peridural space by way of the needle, and then withdraw the needle back over the catheter. As early as 1930, Dogliotti practiced "one shot" lumbar and thoracic peridural anesthesia extensively. His excellent text on anesthesia published in 1939 describes the procedure in detail and discusses its advantages and disadvantages.

continued on next page

* Presented at the 137th Annual Meeting of the Rhode Island Medical Society, at Providence, May 13, 1948.

Details of Technique

With the patient in either the lateral recumbent or sitting position, the skin is prepared in the usual manner for lumbar puncture. A number 3½ ureteral catheter is examined for any possible defects and rinsed with sterile saline. The anesthetic solution may be conveniently prepared by dissolving 1 gram of procaine in 66 cc of sterile normal saline to make a 1½% solution. We have also used 1½% metycaine with good results. This solution may be used for the skin wheal which is made in the 4th lumbar interspace. The skin is then punctured with a Sise introducer to prepare the way for the more blunt Huber point needle. A 16 gauge Huber point needle is examined to note the lettering on that side of its hub which faces in the same direction as the lateral opening at the tip of the needle. The Huber needle is then inserted in the usual manner of lumbar puncture for a depth of approximately one inch. Considerable care is exercised to keep the needle in the midline of the patient's back. At this time, the stylet is removed and a 5 cc syringe containing normal saline is attached to the hub of the needle. The needle is now advanced a few millimeters at a time and the resistance offered to moderate thumb pressure on the plunger of the syringe is checked frequently. When the tip of the needle reaches the ligamentum flavum, an increased resistance to further advancement will usually be noted. At this time, it is wise to use the thumb and index finger of both hands on the shaft of the needle, while the ulnar surface of one hand is held firmly in contact with the patient's back to prevent the needle from plunging too deeply as it suddenly breaks through the ligamentum flavum. Once the needle point has pierced the ligamentum flavum, it will be found that very gentle thumb pressure on the plunger will cause the syringe to empty its solution into the peridural space. In some individuals, the piercing of the ligamentum flavum is not readily appreciated and the absence of resistance to injection will be the only evidence of successful peridural puncture. A few of our patients have shown only mild resistance to injection when the needle point was obviously in the soft tissues of the back; but a complete absence of resistance will not be found before entering the peridural space if the needle is kept in the midline. When it appears that the peridural space has been entered, the syringe is removed and the lettering on the hub of the needle is again noted to make certain the lateral opening of the needle tip is still facing cephalad. The approximate number of centimeters of needle that remain protruding from the patient's back is estimated. This figure subtracted from 9 centimeters (the over-all length of the Huber needle) gives the depth from the patient's skin to her peridural space. The No. 3½

ureteral catheter is now passed through the needle until approximately 6 cm. of catheter have entered the peridural space. This 6 cm. plus the 9 cm. within the needle will give a reading of 15 cm. on the catheter at the hub of the needle. Gentle but steady forward pressure is now made upon the catheter as the Huber needle is withdrawn from the patient. The catheter is never drawn back through the needle for any reason because such a maneuver may shear off a portion of the catheter within the patient's peridural space or lumbar tissues. With the needle removed the centimeter marking of the catheter where it just enters the skin is noted to be sure that the catheter has not been unduly advanced by the forward pressure exerted upon it. The reading taken at this time will equal the distance from the skin to peridural space plus the centimeters of catheter that lie within the peridural space. In the average individual, a reading of approximately 12 cm. shows proper placement of the catheter. Correction is made if necessary by withdrawing the catheter to the proper marking. Adrenalin is added to the previously prepared solution of 1½% procaine or metycaine to make a final dilution of 1:200,000 adrenalin. If using 66 cc of anesthetic solution, 0.33 cc or 5 minims of 1:1000 adrenalin will give a satisfactory dilution. The addition of adrenalin is purposely delayed until this time so that the anesthetic solution may be used without the vasoconstrictor in case of accidental puncture of the dura and arachnoid. A No. 24 needle is inserted into the ureteral catheter and a 20 or 30 cc syringe containing the anesthetic solution is attached to the needle. A test dose of 4 cc is injected as a check against the possibility of subarachnoid anesthesia, and the patient is assisted to the dorsal recumbent position. On a few occasions, we have found it difficult to make the injection even though considerable pressure was exerted upon the plunger of the syringe. The situation has been overcome in each instance by withdrawing the catheter 1 or 2 cm. If signs of subarachnoid anesthesia have not appeared after 6 minutes, the first anesthetic dose of 8 cc is injected. Evidence of peridural anesthesia should appear approximately 10 minutes later, but as much as 20 minutes may be required for the maximum effect of any injection. In patients with long spines, 10 or 12 cc may be needed to establish the desired anesthesia with the first anesthetic dose. We have seen patients with anesthesia through the 11th dorsal segment, but with only partial or incomplete anesthesia of the perineal region. If such is the case, the next injection is increased by 2 cc and the patient is put in about 10 degrees reverse Trendelenberg position to favor a caudal spread of the solution. This will establish complete perineal anesthesia without unnecessary upward spread of the anesthetic level. All of our

anesthesias have been administered with the patient on the delivery table, and we question the advisability of moving these people about with a ureteral catheter in place. They remain on the delivery table until the catheter is withdrawn. It has not been necessary to administer vasoconstrictors other than the adrenalin contained in the anesthetic solution in this series of cases. Minor falls in blood pressure have occurred, however, and equipment for combating any serious disturbance is always at hand. It has been found that an anesthetic dose will last about 45 minutes to 1¼ hours with the procaine solution and slightly longer when metycaine is used. Subsequent injections are given as needed for the patient's comfort or when the level of anesthesia begins to fall below the 11th dorsal segment. The management of labor under lumbar peridural anesthesia is the same as with continuous caudal anesthesia, and the subject has been adequately covered in numerous reports.

Discussion Continued

In considering the possible advantages of the lumbar approach, we would like to state that the possibility of complicating infection with lumbar peridural anesthesia seems very remote if reasonable precautions are exercised. We feel justified in making this statement not from our own brief experience but for the following reason. During the past two or three years, anesthetists throughout the country have accepted and applied extensively an almost identical technique to establish continuous spinal anesthesia. To our knowledge, no cases of complicating infection have occurred. It is granted that the presence of a ureteral catheter in the patient's lumbar tissues must be considered as an avenue of infection if allowed to remain for a long period of time. We have established a policy of limiting the procedure to a maximum of 6 hours to prevent such an occurrence. We also believe it is much simpler and more practical to employ other methods of pain relief for the major portion of a long labor. Peridural anesthesia is not started until it appears likely that the patient's cervix will be fully dilated in less than 4 or 5 hours.

The second consideration of lumbar peridural anesthesia; namely, the possibility of reduced dosage of anesthetic drug, proved to be very gratifying from the start. It was found that only one-third of the recommended caudal dose was required to establish the initial level of anesthesia. When fractional or maintenance injections are needed to prolong the anesthesia, the lumbar technique requires approximately one-half the caudal dosage. We do not believe anyone will question the wisdom of establishing an identical state of anesthesia with a smaller quantity of anesthetic drug. Those of us who employ these local anesthetics frequently are

acutely aware of the disturbances they may cause when absorbed in large quantity by the general circulation. The saving or reduced dosage by the lumbar technique should lower the incidence of such reactions. Also, it seems likely that by working with smaller volumes of solution a more delicate control of anesthetic distribution will be possible. This feature should help to avoid undesirable high levels of anesthesia and their penalty of circulatory and respiratory embarrassment.

In the practice of local, regional, and peridural anesthesia, it is customary to add adrenalin to the anesthetic solution. It serves the dual purpose of delaying absorption and prolonging the anesthetic effect;—a final dilution of 1:200,000 is the customary concentration. It has been our experience that individuals show a marked difference in their reaction to this drug. Rapid pulse, muscle tremors, apprehension, and pounding headache are occasionally seen with as little as 4 or 5 minims of the 1:1000 solution. In the lumbar technique, the combined test dose and first anesthetic dose contain only 1 minim of 1:1000 adrenalin as compared to the 3 or 4 minims administered in the caudal technique.

The literature on continuous caudal anesthesia has described two technical difficulties that may prove less troublesome with lumbar peridural anesthesia. One of these is the occasional inability to maintain a satisfactory level of anesthesia. It seems reasonable to expect a smaller percentage of failures with the lumbar technique because the injections are made about midway between the upper and lower limits of the nerves we hope to anesthetize. With the caudal approach, some of the anesthetic solution must travel twice as far which requires the establishment of a head of pressure in the sacral canal. A second technical difficulty has been described by Hingson (1) as arrest of labor from "prolonged dependent migration of the anesthetic solution through the sieve-like openings of the anterior sacral foramina involving Frankenhäuser's ganglions". Here again it seems probable that because of the smaller volumes employed in the lumbar approach a reduction in the incidence of arrested labor may be achieved. We hasten to add that thus far we have used lumbar peridural anesthesia successfully on only 26 patients and are not qualified to pass judgment on these considerations.

The practicability of peridural puncture will be a disturbing thought to many anesthetists who pause to consider this form of anesthesia. One of us with extensive experience in "spinal" puncture, but with no previous experience in peridural puncture has been able to introduce the catheter into the peridural space in 26 of his first 29 attempts, or 89%. The punctures were made with the patient

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**MINUTE ADOPTED BY THE BOARD OF TRUSTEES
OF BUTLER HOSPITAL, PROVIDENCE,
ON THE RETIREMENT OF ARTHUR H. RUGGLES, M.D.,
AS PHYSICIAN-IN-CHIEF AND SUPERINTENDENT**

THE BOARD OF TRUSTEES has accepted the resignation of Dr. Arthur H. Ruggles as Physician-in-Chief and Superintendent with profound regret but with a sense of its obligation to recognize his right to be relieved from the burdens of the office which on January 1, 1948, he will have filled for twenty-six years — burdens which at all times have been heavy and during the period of the war were extraordinarily heavy.

The Board deems it fortunate that the Hospital is to have the benefit of his counsel in the new office of General Consultant.

The relationship between Dr. Ruggles and the Trustees has been far more than a merely official relationship. It has been one of personal friendship. They hope that it has brought to him a realization of the respect, admiration and affection with which they regard him.

Dr. Ruggles was appointed Assistant Superintendent of Butler Hospital in 1909 upon the completion of his internship at the Rhode Island Hospital. On January 1, 1922, he succeeded Dr. G. Alder Blumer as Physician-in-Chief and Superintendent, and he has served in this office longer than any of his five predecessors.

During his incumbency of this office the Henry C. Hall Dormitory for nurses has been erected; the Hobby Shop has been enlarged and reequipped; and an addition to Ray Hall providing better facilities for church services, occupational therapy and recreation has been constructed. In addition, the other buildings at the Hospital have in many respects been improved, and special attention has been given to the interior decoration of the wards, with a view to rendering the patients' environment pleasanter and more cheerful.

But Dr. Ruggles' chief achievement at the Hospital has been not the enlargement or improvement of its plant but the increasingly successful treatment of its patients. In 1922 the Hospital had approximately the same number of beds as in 1945; but in the earlier year 151 patients and in the latter year 200 patients were admitted. This increase in the number of patients admitted roughly approximated the increase in the number of patients whose improvement was such as to permit their discharge. This success in the treatment of patients has been made possible by the utilization of improved meth-

ods of treatment, and these have required an enlargement of the Hospital's staff. In 1922 the Hospital had five resident physicians; today it has nine. In 1922 it had neither a psychologist nor a social worker. Today it has two psychologists, an interne in psychology and a social worker.

In Dr. Ruggles' view the function of a hospital like Butler Hospital is not limited to the treatment of patients who need hospitalization. He has believed that such a hospital should also take measures to treat the mentally ill in time to avoid the necessity of their hospitalization. To this end in 1945 Butler Hospital established an out-patient clinic. This has rendered valuable service to veterans and others whose cases, if not treated in time, would have required their admission to a hospital.

During his incumbency of the office of Physician-in-Chief and Superintendent Dr. Ruggles has brought about changes in the Hospital's School of Nursing to meet the new conditions affecting the education of nurses. In 1922 the Hospital conducted a small three-year training school; but as time passed, a trend developed toward confining the general training of nurses to schools conducted by the general hospitals. Therefore, in 1939, in recognition of this trend, Butler Hospital discontinued its general training school and established a three-months' course in psychiatric nursing for students in the general training schools. At present in each year about 300 students from fifteen training schools attend this course.

In addition, Dr. Ruggles has had a high sense of the obligation of a physician in his position and of his outstanding ability to participate in the movements directed toward the prevention of mental disease and the improvement of its treatment. He has been one of the leaders in the mental hygiene movement, and was for eight years President of the National Committee for Mental Hygiene. He was one of the organizers of the Rhode Island Society for Mental Hygiene and later its President. For four years he was Secretary, and in 1942 he was President, of the American Psychiatric Association. He has written and lectured widely on the subject of mental health, and in 1932 delivered the Colver lectures at Brown University, the title of his lectures being "Mental Health, Past, Present and Future."

In World War I he served as a major in the Medical Reserve Corps, organized the first neuro-psychiatric unit for service in France, and was successively Psychiatrist to the Second Division, Consultant in Neuro-Psychiatry to the Chief Surgeon of the United States Army in Great Britain and Medical Director of Base Hospital 214, A. E. F. In World War II he was a Consultant to the Secretary of War and the Chairman of the Committee on War Psychiatry.

Any account of Dr. Ruggles' work would be incomplete if it failed to mention the help which he has given to hundreds of persons, having no claim on him except that of their common humanity, who have come to him for counsel in their perplexities and troubles. The value of his help has been immeasurable and his generosity limitless.

Through the years during which Dr. Ruggles has been at Butler Hospital his skill and understanding have lightened the burdens of thousands of patients and their families. His reward must be found in his knowledge of this and in their thankfulness. The debt of the Hospital for all that he has done for its welfare and advancement is of a kind which cannot be repaid. The Board of Trustees can only express to him its gratitude and its hope that, relieved from the burden of administering the Hospital, he may have before him many years of happiness and of service to the causes to which he has devoted his life.

CONTINUOUS LUMBAR PERIDURAL ANESTHESIA IN OBSTETRICS

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in the lateral recumbent position except for one instance where the sitting position was used for an obviously difficult spine. It is expected that with more experience the percentage of successful punctures will be in the nineties. A more frequent use of the sitting position will be used, if necessary, to obtain a highly practical number of successful peridural punctures. The authors prefer the lateral recumbent position for the patient's comfort. Unquestionably, the inexperienced anesthetist will have frequent failures until he develops the "knack" of peridural puncture. It should be recalled that inability to enter the sacral canal is by no means a rare occurrence in the practice of continuous caudal anesthesia.

Summary and Conclusions

The authors are of the opinion that continuous caudal anesthesia will be used more extensively in the future because of recent reports which indicate a reduced fetal mortality in patients delivered with this form of anesthesia. In addition to the possibility of saving infants, it offers a dramatic and complete relief of pain during the most trying por-

tion of labor. Some of the hazards and complications of caudal anesthesia have been mentioned briefly.

A closely related anesthesia procedure; namely, the ureteral catheter technique of continuous lumbar peridural anesthesia has been described in detail and its apparent advantages considered. Our experience has been limited to 26 cases. In an additional 3 patients, we were unable to establish lumbar peridural anesthesia because of inability to locate the peridural space. It is felt that the percentage of successful anesthetics will increase with more experience. We believe the catheter technique of continuous lumbar peridural anesthesia is worthy of a more extensive trial and we recommend it for consideration to anesthetists engaged in obstetrical anesthesia.

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OBSERVATION AND DIAGNOSIS

*There was an old man who said: "Hush,
I perceive a young bird in that bush."
When they said "is it small?"
He replied "not at all,
It is three times the size of the bush."*

EDWARD LEAR

WILLIAM HUMBOLDT, the elder brother of the more famous Frederick the naturalist, once remarked that "to behold is not necessarily to observe, and the power of comparing and combining is only to be obtained by education." Edward Lear, who like many humorists had a strong tincture of common sense in his make-up, suggested the same idea in the verse quoted above, for to perceive is something more than to see, and in medicine one of the chief objects of training should be to sharpen the powers of perception, which while they normally vary considerably in acuity in different people, can definitely be improved by practice.

Diagnosis, as an experienced physician can testify, is at times a very simple matter and at other times a very complicated performance; but in either case one of the most important factors in reaching a conclusion is the power to observe accurately. It might be surmised that in these days of specific or near-specific technical diagnostic procedures the

cultivation of the powers of observation, which include not only sight, but hearing, touch and even smell, has become less necessary than it formerly was, and there is little doubt that the mere existence and multiplicity of such tests has made many physicians careless about cultivating their observational powers, and indeed about some other essentials such as competent history taking. Why bother to observe acutely, to compare, to combine and to deduce, when the X-ray, the Electrocardiograph, or some bacteriological, chemical, or serological tests may give you the answer without the painful effort of thinking?

The answer to this type-of reasoning is that it is fallacious because acute powers of observation and deduction are often needed in the interpretation of technical results, because none of the common technical tests is one hundred percent efficient, because no one of the interpreters is always right, and because, for these reasons, the diagnosis of

disease, particularly in obscure and atypical instances, can be reached only by careful consideration of all the facts and not always even then.

The Wassermann test, for example, fails in a certain percentage of patients with active syphilis and is occasionally positive in diseases other than lues; the Widal reaction and all comparable agglutination tests are none of them one hundred percent sure fire, and may be hangovers from infections long past and are occasionally non-specific; the radiologist, who interprets shadows, cannot be expected to hit the bullseye every time; and the tracings procured by Electrocardiography are sometimes ambiguous and even misleading. It is doubtless true that in terms of percentage the errors in many of these tests are small, but while those dealing with infections are fairly specific there are others which merely point to damage to some special organ, liver function tests for example, but do not reveal the particular etiological factor. They are like the revelations of cerebral localization which indicate the site but not the nature of the lesion.

We must, I think, conclude that no matter how many specific technical methods are devised, there will always be occasion for the use of cultivated powers of observation and deduction in diagnosis. A dermatologist who fails to recognize syphilis because the Wassermann happens to be negative, or an Internist who misses a case of typhoid fever because the Widal reaction is absent, are not very brilliant exponents of medical science and art. We have only to read the records of our medical ancestors who flourished before the technical era to be convinced of the possibility of recognizing even obscure cases of disease by the use of good histories, thorough physical examinations and a vigorous use of the gray cortex. This is not to decry the value of modern methods, but to emphasize the importance of continuing to cultivate some of the older techniques which are in danger of being overshadowed at a time when their use is still of the greatest importance.

G. B.

SEAL OF APPROVAL

The announcement by the Health Insurance Committee that the Rhode Island Plan, the voluntary prepaid surgical-obstetrical program of the Society, has been awarded the Seal of Acceptance of the Council on Medical Service of the American Medical Association adds further prestige to it. Approval by the Council on Medical Service is granted only after the program is carefully checked as regards its sound operation and careful medical supervision.

Within the past month participating physicians have been supplied with informative brochures and with a pad of direction to pay and physician agree-

ment forms. Several insurance companies have announced that they are preparing promotional campaigns for the Fall, and with many sales already reported we look forward confidently to the development of the program in the coming months.

It is interesting to note that the Maine and Tennessee state medical associations have, by vote of their respective Houses of Delegates, decided to develop their surgical insurance plan along the line of ours. Others already in the field with us include Wisconsin and Illinois.

The progress of plans utilizing private insurance companies received support at the recent AMA meeting when the Council on Medical Service agreed to assist the various interested states in preparing informative data on this type of program. Representatives of nine states met in Chicago in June to outline procedures to be followed in extending prepaid insurance for medical care through policies endorsed by state medical societies and merchandised by the insurance industry.

MEDICAL TEACHERS

As we have pointed out previously, the fact the Rhode Island has no medical school does not in any manner whatever indicate that the medical personnel in this state ranks less equally with those of other states in all phases of service, including medical teaching. On several occasions we have noted the accomplishments of, and the honors to, Rhode Island physicians.

Again we report with pride the appointment of four Fellows of the Society who have been selected during this summer for teaching roles in foreign lands. On July 1, Dr. Meyer Saklad, director of the anesthesia department at Rhode Island hospital, was selected as a member of a medical mission which has conducted lectures for European physicians during the past six weeks in Warsaw, Piekary, at the University of Krakow, the University of Turku, and at Helsinki.

This month Dr. Alex M. Burgess, former chief of medical service at Rhode Island hospital, and Dr. Peter Pineo Chase, editor of this JOURNAL, and also president-elect of the Society, start a two month lecture course in Germany. Their task will be to bring up to date physicians who have been cut off from medical developments for years because of concentration camp or displaced person camp detention.

To Brazil has gone Dr. Eugene A. Field who was invited to deliver lectures on radiology at the medical school in Rio De Janeiro, and who will also give a scientific lecture in Portuguese to the entire medical profession of the city during his visit.

It is a source of gratification for all Rhode Island Physicians to note the recognition to these members of the Society. For Doctors Saklad, Burgess, Chase

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and Field the acceptance of the teaching assignment, with all the work it entails, represents a notable personal contribution to the advancement of medicine and the health of the people in the countries they will visit.

THE FISKE FUND

The recent action of the court in authorizing the investment of the Fiske Fund of the Society in securities that will realize a greater return, thus providing income to permit the award of an annual cash award for the prize essays, is indeed good news. The ruling of legal counsel for the fund in 1941 that the spending of more than the usual income was to be considered a definite breach of trust resulted in the suspension of activities as regards the annual Fiske Essay. The annual income from the bank deposit would not suffice for the payment of the prize award and the incidental expenses necessary for the publicizing of the contest.

Hence the recent action which resulted after the Council of the Society had authorized the Fiske Fund Committee to seek court transfer of the funds to government security bonds, or other reputable investment that would provide a greater annual revenue. By this action it is hoped that within the next year the fund will be in a position to permit a \$150 prize, and also provide the incidental expenses of the contest. The fund at present totals \$12,954.21.

It was in 1835 that the Society received through the will of Dr. Caleb Fiske the original trust of \$2,000 the income of which was to be used to pay a premium or premiums for the best treatise or treatises on the subject proposed by the Trustees of the fund. The first award was made to Dr. T. H. Webb in 1836 whose essay was on "Rheumatism, Its Causes and Treatment". Since that date 69 additional awards have been given, the most recent in 1941 to Dr. Adolph Eckstein of Providence for his essay on "The Surgical Treatment of Peptic Ulcer."

THE C. V. CHAPIN FELLOWSHIP

The creation by the late Mrs. Charles V. Chapin in her will of a Charles V. Chapin Fellowship for Research in Contagious Diseases adds another outstanding contribution to the memory of her famous husband whose lifetime in public health work won for him world-wide renown.

Through this bequest the governing board of the Chapin hospital is authorized to designate from time to time a person to carry on research work in the study of contagious diseases. The gift is made on the express condition that the hospital shall provide at its expense room, board and suitable

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equipment at the hospital for the person designated for the fellowship award.

The recipient of the fellowship, upon accepting the appointment, is expected to devote his entire time, free from routine work at the hospital, to research work.

Should the governing board of the hospital find that it is unable to comply with the conditions of the will, or if in any consecutive period of two years no person is carrying on the research work, the entire trust terminates and is transferred to the Rhode Island Foundation which may in its discretion continue the Chapin Fellowship, or otherwise dispose of the funds for charitable purposes.

We are certain that the governing board of the hospital will never have to relinquish the trust, and we hopefully look forward to some worthwhile research in the study of contagious diseases by Chapin Fellows in the years ahead.

PHYSICIANS NEEDED FOR DRAFTEE EXAMINATIONS

Members of the Society interested and willing to assist the U. S. Army and U. S. Air Force Recruiting Service in the physical examination of draftees are requested to communicate with Captain Kirke B. Everson, Jr, recruiting officer, at the Recruiting Main Station at 37 Exchange Place, Providence.

The preliminary induction examination consists of both a mental and physical examination. All examinations will be paid for on a fee basis, as follows: \$5 for the first man to be examined; two dollars for each additional man examined, with a maximum of \$25 paid for any one day's work.

The Recruiting Office anticipates a daily flow of 35 to 50 persons for physical examinations by late September or early October. Hence two physicians as a minimum will be needed for each day for about three hours (between 10 a.m. and 2 p.m.). Specialists will also be needed by the Service to determine doubtful cases.

LIBRARY HOURS

During the month of August the Medical Library will close at 1 p.m. daily, except Saturday when the closing hour will be 12 m.

INDUSTRIAL HEALTH

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THE GENERAL PRACTITIONER IN NEW ENGLAND HOSPITALS

(A report with comments to the Council of the New England State Medical Societies, presented by the Executive Secretary at the Annual Meeting, at Boston, Massachusetts, April 21, 1948.

THE ROLE of the general practitioner in American medicine has received increasing attention in the past few years. Two factors have contributed to bring about this revival of interest — (1) The tremendous trend towards specialization which has resulted in a more notable division within the profession, and (2) the adoption by hospitals of staff rules and regulations restricting practice in hospitals.

As pointed out by Johnson¹ there were about 5,100 residents in hospital residencies at any one time before the war, whereas today there are some 12,000. It is not within the province of this limited report to discuss at any length the reasons prompting such a sizeable increase in the number of medical graduates who are continuing training to become specialists. That the field of modern medicine has become increasingly complex, thereby necessitating the development of specialties with which the public is becoming more and more familiar, is well-known.

But physicians trained for specialty work naturally locate in urban areas, and the question may well be asked whether our communities will be in a position to absorb the specialists in the proportion now being trained. The various American Boards are reported to be concerned by the large numbers seeking certification. Therefore a study might well be initiated of the factors contributing to the trend towards specialization. Undoubtedly such a study would include in its findings the tendency of some hospitals to limit their staff appointments to those physicians with Board certification.

Recognition that the general practitioner is being restricted more and more as regards hospital prac-

tice has been noted in many publications. The Journal of the American Medical Association editorially² cited the position of organized medicine on the matter last August, stating that

"Any rule barring a physician from staff privileges because he does not possess a certificate from one of the specialty boards or membership in a special society is not in accord with the expressed policy of the American Medical Association and the Advisory Board for Medical Specialties. Hospital staff appointments should depend on the qualifications of physicians to render proper care to patients as judged by the professional staff of the hospital and not on certification or special society membership."

Of paramount importance is proper medical care to patients. Unquestionably the average person wants capable and experienced physicians for what is termed specialty work, in or out of the hospital. But at the same time he considers the general practitioner, or as he is more familiarly called, the family doctor, trained to render care for the great majority of illnesses regardless of their severity. The situation is most perplexing when the general practitioner, for example, treating a child for pneumonia and wishing to give penicillin in the hospital has to relinquish the patient to a specialist because of hospital restrictions.

This example can be multiplied manyfold, and it becomes increasingly embarrassing to the physician in general practice, and most confusing to the patient whom we teach to seek advice from the doctor of medicine. With the tremendous growth of hospitalization and surgical-medical insurance plans the problem is augmented by the increasing demand for medical care in the hospital. The question may well be asked — should the general practitioner not have part in the care of his patient whom he refers to the specialist, so that the medical care given in the hospital will be his intimate knowledge when the patient is returned to him?

In an effort to find out what the privileges and restrictions are relative to practice in the hospitals in New England by general practitioners, an inquiry was directed to approximately fifty hospitals in the region. Replies were received from twenty-

continued on page 500

¹ The General Practitioner and His Opportunities, Victor Johnson, M.D., J. Omaha Mid-West Clinical Society, Jan. 1948.

² The hospital and the general practitioner (ed.), J.A.M.A. 134:1484 (Aug. 23) 1947.

Report of the Committee on Therapy of
THE AMERICAN ACADEMY OF ALLERGY
on HYDRYLLIN

The results of the study:

		60% to 100% EFFECTIVE (Regarded as "Good")	40% to 60% EFFECTIVE (Regarded as "Fair")	0% to 40% EFFECTIVE (Regarded as "Poor")
Hay Fever	790 CASES	304 (38%)	234 (30%)	252 (32%)
Asthma	397 CASES	119 (30%)	82 (21%)	196 (49%)
Pollen Asthma	226 CASES	73 (32%)	55 (24%)	98 (44%)
Vasomotor Rhinitis	130 CASES	20 (16%)	42 (32%)	68 (52%)
Urticaria	24 CASES	4 (17%)	8 (33%)	12 (50%)
Eczema	3 CASES			3
TOTAL	1,570 CASES			

Side Reactions

No Reactions 1,219 Cases (72%)
 Moderate Reactions . . 314 Cases (20%)
 Severe Reactions . . . 126 Cases (8%)

Conclusion: From these figures it would seem that the preparation has a fair degree of effectiveness in hay fever. In the asthmatic cases, both those with asthma due to pollen and those having asthma from other sources, the figures of the effectiveness of the drug are more impressive than those of other antihistaminics.

ON THE basis of the study made by the Committee on Therapy of The American Academy of Allergy, **HYDRYLLIN** is an effective and well tolerated antihistaminic for use in the treatment of allergic manifestations.

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Research

*In the Service
 of Medicine*

THE GENERAL PRACTITIONER IN NEW ENGLAND HOSPITALS

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seven, including at least one answer from each of the New England states. Some of the large hospitals evaded the question. Nearly all indicated that the tendency is towards concentration in specialties for staff privileges, with the specific criterion qualification by one of the various Boards or Colleges. Very few give the general practitioner much opportunity to render care for the majority of his patients. The most favorable report in this respect, from a 480 bed general hospital, stated:

"General practitioners may be appointed to any position in our hospital by the Board of Trustees on the recommendation of the Staff Advisory Committee which considers their general and specialized qualifications. There is no staff rule or regulation which prohibits the general practitioner from participating in any activity on the service to which he is assigned if he is considered qualified by the chief of the service."

"In practice, the general practitioner or the so-called 'Specialist' who does not limit his practice may be promoted to a position on our staff in any medical or surgical specialty provided he has demonstrated that he is qualified for the position. Accordingly, there are instances in our staff where men, who must be technically called general practitioners, have achieved the rank of seniors in specialty services."

"Usually the man with a house service in our hospital limits his practice in the hospital to that service although he may practice general medicine outside of the hospital. There are very few instances where men who are not classified as obstetricians deliver babies in the hospital and yet are members of other specialty services. In practice there are becoming fewer as time goes on."

Many hospitals either have or contemplate a "credentials committee" to decide on the privileges of the physicians to be on the active staff, in accordance with College and Board recommendations. The privileges are for the most part in three categories, permitting (1) full privileges, restricted to special field (i.e. Medicine, Surgery, etc.) (2) Intermediate privileges, the performance of certain procedures without supervision, and certain others with supervision; and (3) Minor privileges, allowing very few services without supervision.

The ramifications of this problem are many. The issue is one that can work to the disadvantage of organized medicine at a time when strength and unity of membership is of paramount importance. The public seeking medical service has every reason

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to be concerned with the regulations for the staffing of hospitals wherein an increasing amount of that service may be given in the future.

The suggestion appears worthy of consideration that the Council of the New England State Medical Societies establish a committee of its own, or for it, to make a complete study of this situation in the New England area in order to rationalize in this region what might be done in the best interests of the public and the profession to give the general practitioner hospital privileges.

APPENDIX

The Role of the General Practitioner in New England Hospitals

Note: The following abstracts are from replies to an inquiry as to privileges and restrictions for general practitioners in hospitals in the New England states. Names of hospitals are withheld.

Hospital "A" (General, 250 beds) (Population of Community over 250,000)

"In reply to your recent letter, we would say that we have a closed staff at this hospital and only members with regular appointments to the visiting staff are permitted to treat patients in the hospital."

* * * *

Hospital "B" (General, 281 beds) (Population of Community under 200,000)

"In answer to your letter of March 9, at the moment we have a number of men on our courtesy staff who are allowed the privileges of the hospital for their private and semi-private surgical patients. A small number of these are general practitioners."

"At the moment any medical man, a graduate of an approved medical school, may be granted the privileges of the hospital for his private and semi-private medical patients."

"It is now under discussion whether or not we are going to close the hospital to our appointed staff. Now our courtesy staff is provided the conveniences of the hospital but does not contribute to its educational program or charity work, and we think this is erroneous. I strongly suspect that this change will take place in the very near future."

* * * *

Hospital "C" (General, 172 beds) (Population of Community under 100,000)

"Relative to your letter of March 9th, I think perhaps it will be more pertinent to give you the policy of this hospital as of January 1, 1949, since at that time we are dropping our present policies. In effect, there has been established a credentials

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THE GENERAL PRACTITIONER IN NEW ENGLAND HOSPITALS

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committee. This credentials committee consists of the chief of each service. The function of this committee is to decide on the privileges of the men on the active staff. At the present time each man on service has been notified that beginning January 1, 1949, his privileges will be limited to the service to which he is now assigned. He may have major privileges with or without supervision and minor privileges with or without supervision. Additional privileges on other services may or may not be granted but may be applied for and would depend upon the qualifications of the man in the judgment of the Credentials Committee."

Hospital "D" (General, 294 beds) (Population of Community under 125,000)

"Referring to your communication of March 9, I wish to advise you that we have on our Courtesy Staff several general practitioners who have, through their experience, become qualified in major surgery and obstetrics as well as medicine and such Staff members are allowed to practice their profession here at——Hospital.

"There have been special instances where the character of the work performed has been felt by the Staff not up to standard and in such cases the Staff member has been restricted in his work or allowed to continue work under supervision.

"In the case of new men applying for Staff privileges, they have to specify as to what branch of medicine they are particularly interested in and after a review by the Credentials Committee and recommendations received, the Staff act on the applications, in most cases granting the privileges, and in others, granting less than what the applicant requested."

* * * *

Hospital "E" (General, 115 beds) (Population of Community under 50,000)

"Ordinary courtesy privileges given to the General Practitioner, allows him to take care of his medical cases, minor traumatic surgical cases, and obstetrical cases. If he is a duly qualified specialist in any branch, he is in turn, given privileges, Surgical and otherwise, as prescribed for his respective specialty."

* * * *

Hospital "F" (General, 769 beds) (Population of Community under 200,000)

"The policy of the——Hospital is that general practitioners may be admitted on the courtesy staff of the hospital. We do not have any special section for general practice, nor do we allow the

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general practitioners to engage in any of the specialized procedures of medicine. At the present time the general practitioner is allowed to bring medical and pediatric patients to the Hospital and care for them as his own private patients. All general practitioners are under the Chief of Medicine or of Pediatrics, and their work is subject to the review and control of the Chiefs of the respective services.

"In a few selected circumstances, general practitioners are allowed to do normal obstetrics. These individuals apply for these privileges and are passed upon and recommended by the Chief of Obstetrics and Gynecology. If such courtesy privileges are given, the general practitioner does his normal obstetrics under the direction and control of the Chief of Obstetrics and Gynecology.

"Our general thinking at this time, and I believe that this attitude will continue, is that the general practitioner should continue to be afforded privileges in the hospital. It is by this method that the Hospital can assist in postgraduate education of doctors, and make available easily consultations whenever the practitioner feels that the problem warrants. It also provides a continuity between the home care of the patient and the hospital care, and yet if properly controlled, does not subject the patient to improper medical care."

* * * *

Hospital "G" (General, 182 Beds) (Population of Community under 125,000)

"The Staff of——Hospital is made up of Honorary, Retired, Consultant, Active, Out-Patient, and Courtesy members. All of these men have the privilege of referring patients into the Hospital, either as private or ward cases.

"In accordance with the desires of the American College of Surgeons and the Standardization Committee, special committees have been appointed to classify all members of the Staff for Surgical, Obstetrical, and T & A privileges. Classification of the members of the Staff has been reviewed with careful deliberation and carried out only with the interest of the public welfare in mind and the maintenance of high standards of medical care in the Hospital.

"The classification for Surgery is as follows:

Group I permits full privileges in the Operating Room.

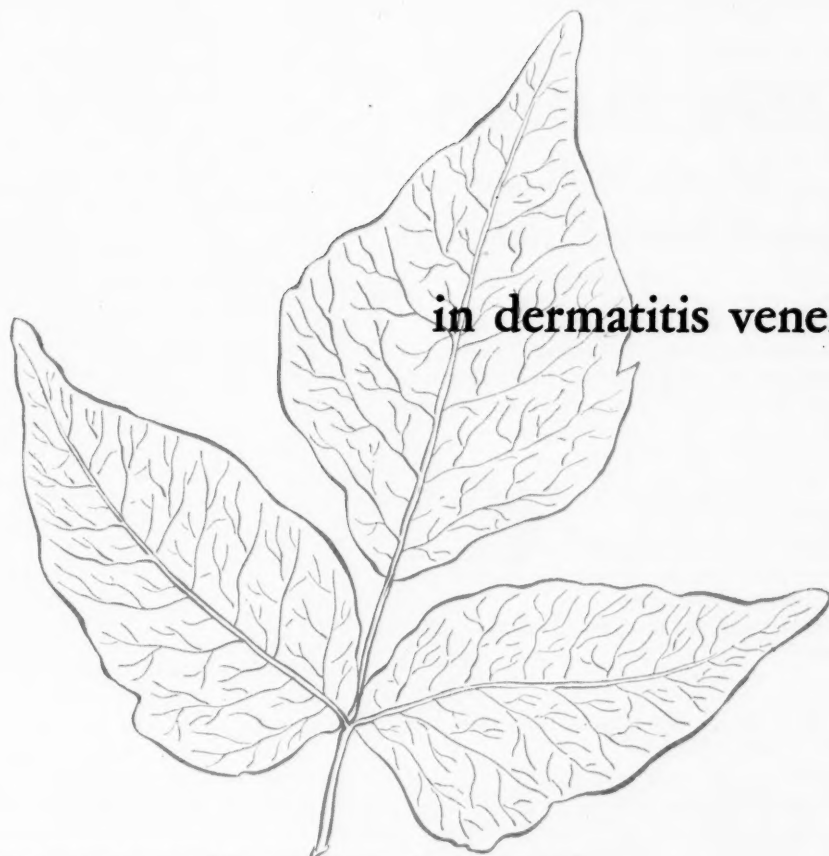
Group II required an assistant qualified from Group I.

Group III men have no operating privileges.

"The classification for Obstetrics:

Group I permits full and unrestricted privileges in Obstetrics, except Caesarean Sections,

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THE GENERAL PRACTITIONER IN NEW ENGLAND HOSPITALS

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which are certified by the Surgical Committee.

Group II permits the use of low forceps; other forms of manipulative deliveries must be done in the presence of an assistant qualified in Group I.

Group III permits routine normal deliveries. No forceps or manipulations of any kind are permitted.

"Any Courtesy Staff man attending a medical case in the Hospital is required to obtain a Consultant in any serious case, unless he is a Group I man from one of the other hospitals. However, consultations are earnestly requested in all serious cases and in all cases where a Caesarean section is indicated."

* * * *

Hospital "H" (General, 227 Beds) (Population of Community over 250,000)

"The facilities of the Hospital have for many years been used to capacity by men specializing in surgery and internal medicine.

"At present there are no general practitioners on the staff."

* * * *

Hospital "I" (General, 164 Beds) (Population of Community under 50,000)

"The active medical staff shall consist of those physicians who have been selected to attend free patients in the hospital and to whom all such patients shall be assigned. Only members of the active medical staff shall be eligible to vote or hold office.

"No physician who is not resident in the community shall be eligible for membership on the active medical staff. Appointments shall be made by the governing board, after recommendation of the active medical staff."

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Hospital "J" (General, 449 Beds) (Population of Community over 250,000)

"We have at this hospital no policy for or against staff privileges for general practitioners, as our staff is a closed staff. I should say that some of the members of our Medical Service can be regarded as general practitioners although not quite in the same sense that general practice is conducted in our smaller cities and towns."

Hospital "K" (General, 226 Beds) (Population of Community under 50,000)

"At the present time, our established policy is to extend those privileges to a man which he is capable of fulfilling, regardless of formal educational or Board qualifications. It is true that most of the senior men on the specialized services are Board members and do restrict their practice as to the specialty which they represent.

"At the present time, we are at work on a system of staff evaluation."

Hospital "L" (General, 170 Beds) (Population of Community under 150,000)

"The medical staff of the——Hospital is a closed staff restricted to specialties in their respective divisions, with only one or two exceptions are either Diplomates of their respective Boards or eligible for certification. At the present time there are seventeen members on our staff. There are two on our honorary staff for they have retired from practice.

"At the present time general practitioners are not permitted staff privileges. Their patients must be referred to a member of our active medical staff."

* * * *

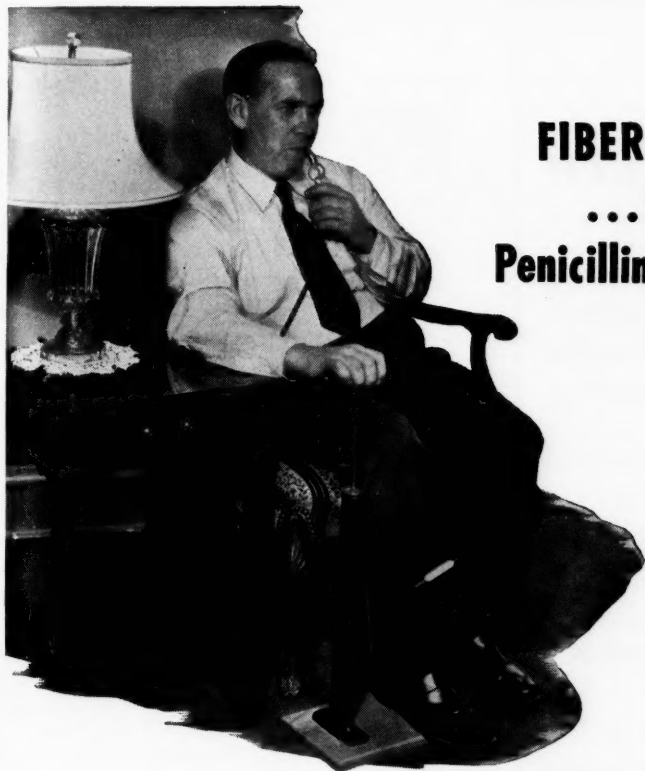
Hospital "M" (General, 215 Beds) (Population of Community over 250,000)

"The physician, when he applies, makes application for that particular specialty classification of the staff organization in which he is interested and in which he is competent — based upon his education and training. We do not have a staff classification for General Practitioners as such, although many of the physicians who are in the Internal Medicine division of the staff organization do general practice.

"Upon receipt of application, the physician's background and qualifications are very religiously reviewed by the Committee on Credentials, and their recommendation is sent to the governing board of the hospital through the Medical Executive Committee."

* * * *

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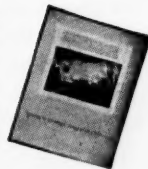


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†Einke, Walter, M.D., Simplification of penicillin aerosol therapy for home treatment, American Practitioner 1: 643-644, Aug. 1947.

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THE GENERAL PRACTITIONER IN NEW ENGLAND HOSPITALS

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Hospital "N" (General, 555 Beds) (Population of Community over 250,000)

"There has been no action taken, and there are no defined policies relative to restrictions to General Practitioners.

"However, the relationship of the general practitioner to the general staff structure of _____ Hospital is under constant study.

"All doctors on the staff of the _____ Hospital have the privilege of bringing private patients and their privileges in this connection are defined by the Credentials Committee, in accordance with the qualifications of the individual.

"It is true, of course, that general practitioners are not and have not for years been allowed to practice the surgical specialties."

Hospital "O" (General, 308 Beds) (Population of Community under 125,000)

"Major privileges in any service will permit the physician to treat patients, on that service, for any cause.

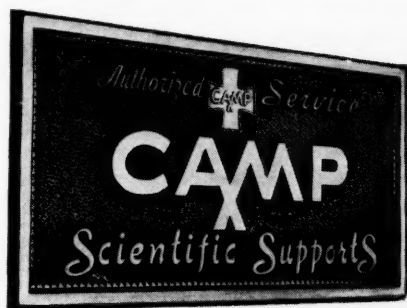
"A physician with intermediate privileges may perform in his service any procedure under the supervision and in the presence of any member of the Active, Associate or Consulting Staffs of said service with major privileges and after a consultation with such member at least twelve hours before operation, except in emergency, in which case consultation must be held before patient is under anesthesia.

"A physician with intermediate privileges on the Surgical service may perform the procedures listed under "A" without supervision; and under "B" under the supervision of a member of the Active or Consulting Staff of the service in which the procedure is to be performed.

"A. Without Supervision

1. Hemorrhoidectomy
2. Saphenous ligation
3. Closed reduction of simple fractures
4. Incision and drainage of infection not involving cavities
5. Fissure in ano
6. Fistula in ano
7. Amputation of digits
8. Suturing lacerations not involving tendons or nerves
9. Removal of simple cutaneous tumors
10. Ingrown toenails
11. Dilation and Curettage
12. Tonsillectomy and adenoidectomy
13. Hydrocele, uncomplicated
14. Skin grafts; Rividen and Thiersch only.

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"B. With Supervision

Any other minor or any major operation.

"A physician with minor privileges may perform in his service any of the procedures listed above under "A" under the supervision and in the presence of any member of the Active, Associate or Consulting Staff of said service.

"A physician with minor surgical privileges may perform any or all of the following procedures:

1. Cutting tongue tie
2. Removal of wens or simple lipomata, warts and uncomplicated moles
3. Incision and drainage of simple infections not involving tendon or facial planes or organs
4. Incision of furuncles
5. Paracentesis
6. Suturing of lacerations involving integument only
7. Incision peritonsillar abscess
8. Tonsillectomy in patients under 14 years of age
9. Adenoidectomy
10. Circumcision
11. Transfusion
12. Intravenous medication or venupuncture
13. Spinal puncture and other medical diagnostic and therapeutic operative procedures
14. Sclerosing of veins."

* * * *

Hospital "P" (General, 162 Beds) (Population of community over 250,000)

"All appointments to the Staff of the——— Hospital will be classified under Medicine, Surgery, Obstetrics and Anaesthesia. A member cannot hold both Medical and Surgical appointments,

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but must confine his work in the Hospital within the scope of either Medicine or Surgery. Appointments in Obstetrics and Anaesthesia, however, may be given to appointees in either Medicine or Surgery, if the applicant is properly qualified.

"Appointment to the Medical Staff gives to the physician the right to use the Hospital and its facilities for his private patients for the practice of the following:

General Medicine

Care of normal Obstetrical cases including those requiring minor plastic repairs

Simple Anaesthesia (Nitrous Oxide and Ether anaesthesia)

The privilege of assisting at major operations.

"Surgical Appointments with Major Privileges:

1. General Surgery. Major Surgical privileges may be given to Fellows of the American College of Surgeons or Diplomates of the American Board of Surgery.

2. Limited Major Privileges. Limited major privileges in General surgery may be given to the Junior members of the Active Staff, subject to the approval of the active Senior Surgical Staff.

3. Major Privileges in Special Branches of Surgery. Major privileges in special branches of surgery are given to Fellows of the American College of Surgeons or Diplomates of the American Board in their specialties. Surgeons having Major privileges in certain specialties only are limited to that specialty in this hospital.

"Surgical Appointments without Major Privileges:

Surgical appointments without major surgical privileges are given to those who have had special training in Surgery, but do not qualify for major privileges. Such appointments may permit the appointee to perform major surgery but only under the direct supervision of a member of the Surgical Staff who is a Fellow of the American College of Surgeons or Diplomate of the American Board of Surgery."

Obstetrical Appointments with Unlimited Privileges:

Such appointments are given to Fellows of the American College of Surgeons and to Diplomates of the American Board of Obstetrics and Gynecology, and the Chief of the obstetrical service of the Active Staff.

"Obstetrical Appointments with Limited Privileges:

Such appointments are given to those who have had adequate training in Obstetrics, but do

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*Biolac dilution is easily calculated—quickly prepared:
1 fl. oz. Biolac to 1½ fl. oz. water per pound of body weight.*

Biolac



"Baby Talk" for a Good Square Meal.



THE GENERAL PRACTITIONER IN NEW ENGLAND HOSPITALS

continued from page 508

not qualify for unlimited privileges. The appointees may perform all obstetrical procedures except Caesarian sections.

"Anaesthesiology:

Physicians on Medical Staff who are qualified in anaesthesia shall be given the privilege of practicing unlimited anaesthesia in the hospital, by the executive committee, after consultation with the Anaesthesia Staff."

* * * *

Hospital "Q" (General, 152 Beds) (Population of Community under 100,000)

"The Active Staff shall consist of all department or service Chiefs and those physicians who are annually assigned to attend all free patients who have not their personal Physicians, hereinafter called "Service Cases." Members of the Active Staff should preferably be F.A.C.S., or F.A.C.P., or a Diplomat of one of the Specialty Boards, or if there is no Board, a member in the National Organization which represents that specialty, or American Dental or National Dental Association. Members of the Active Staff only shall have active or passive vote in Staff Meetings."

* * * *

Hospital "R" (General, 527 Beds) (Population of Community under 200,000)

"It is our policy to send a letter to the doctors who are granted General Practitioner Privileges stating in full a detailed definition of what they are allowed to do."

Appointment to the courtesy staff with general minor privileges is set forth as follows:

"Minor Privileges have been defined as follows:

"Medicine: General Medical Cases may be cared for except that, for the protection of the Hospital, major problems in Medicine, such as Coma-Mental-Severe Cardiac conditions, or Pneumonia, shall

RHODE ISLAND MEDICAL JOURNAL

have a consultation with a member of our Active Medical Staff.

"Surgery: Any operative procedure which can be done in a doctor's office, or in our Emergency Room, without anesthesia.

"Under Minor Surgery we have also included Circumcision, Incision and Drainage of superficial abscesses, and Suturing of Superficial wounds, which may be done with Anesthesia.

"Obstetrics: Minor Obstetrics includes only these procedures:

Spontaneous deliveries

Outlet (low) forceps with head visible

Frank breeches in multipara

Repair of first and second degree lacerations and episiotomies

Rupture of membrane after onset of labor

"It does not include the following procedures. These may be performed only by those having specialist privileges in obstetrics:

Cases complicated by constitutional diseases, such as heart diseases, diabetes, etc.

Caesarean Section

Bag Induction

Repair of third degree laceration

Version and extraction

Toxemias of pregnancy

Primigravidous Breeches

Multiparous footlings

Mid forceps

Scanzoni Maneuver

And all other obstetrical complications.

"Orthopedics: Fractures with no displacement nor joint involvement, as read by the X-Ray Department, and which requires no anesthetic.

"Major Surgical Privileges are granted only to those who have complied with, or are in the process of complying with, the American Board requirements in the Various Specialties. We shall be glad to extend further privileges upon request, and on evidence of Special training."

* * * *

Hospital "S" (General, 141 Beds) (Population of Community under 50,000)

"All practitioners are given courtesy privileges. Men on the staff are not given preference in hospital admissions. Every patient is admitted in rotation excepting, of course, emergencies. Places are always found for these.

"After April 1, 1948, the heads of the various services must be certified. Young men are admitted to the staff as associates and are given five years in which to obtain certification. If this is not accomplished they are continued as associates. The rule is not retroactive and any man now on the staff is retained."

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BIBLIOGRAPHY: 1. United States Dispensatory, ed. 24, Philadelphia, J. B. Lippincott Company, 1947, p. 1446. 2. Wiesbader, H., and Filler, W.: *Am. J. Obst. & Gynec.* 51:75, 1946. 3. Allen, W. M.: *South. M. J.* 37:270, 1944. 4. Lyon, R. A.: *Am. J. Obst. & Gynec.* 47:532, 1944. 5. Groper, M. J., and Biskind, G. R.: *J. Clin. Endocrinol.* 2:703, 1942. 6. Soule, S. D.: *Am. J. Obst. & Gynec.* 45:315, 1943.

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RHODE ISLAND MEDICINE

Its Problems and Its Solutions

Prepared by the Committee on Public Policy and Relations of the Rhode Island Medical Society and published in the Providence Evening Bulletin, June 14-20, 1948.

I

THE EVENING BULLETIN recently completed a series of articles on American Medicine,—Diagnosis and Prescription. The author of the articles reportedly sought thoughtful answers from the nation's top physicians and public health experts to such questions as these:

Is there a shortage of physicians? Is socialized medicine the solution for our medical problems? Is there too much specialization? Why is it hard to get a doctor in an emergency? How can the cost of medical care be reduced? What are the major trends in American medicine?

The author of the articles reportedly visited key medical centers in this country, and talked with scores of leading physicians, medical educators, public health experts and others qualified to speak on the subject. The articles, according to the *Bulletin*, represented a "synthesis of the best thinking that is being done on the problem of how to bring adequate medical care to the people of the United States."

The Committee on Public Policy of the Rhode Island Medical Society has requested the opportunity to answer in this newspaper some of the conclusions incorporated in these articles.

The Committee is one entirely of physicians. It speaks with honesty, conscious of its obligations to the people of Rhode Island. It does not attempt to speak for the medical profession of the entire country, nor of the medical problems and their solutions throughout the nation, except in respect to phases where such problems affect Rhode Island directly.

The Medical Profession is not an organized group. It is a profession of individuals who are subject to all the human frailties of individuals. The Medical Society is merely an association of the individual physicians for the promotion of the science and art of medicine and the betterment of public health. The physicians of this state therefore claim for themselves no other prerogatives than those of any other citizens.

The Medical profession has read the articles in the *Evening Bulletin* that presented views and conclusions attributed to "the men who mold the na-

tion's health program". Who are these men? By what authority do they speak as experts? and why did they not authorize that their names be published in connection with their statements?

This Committee, speaking for the Medical Society, recognizes that the medical profession is subject to faults such as beset every profession or business in some manner or other. The Committee recognizes the need for and the value of constructive criticism, and therefore it has no desire at any time to disregard any justified complaints involving the practice of medicine in Rhode Island.

The members of this Committee claim no reportorial ability and the presentations that follow are an attempt at simple, factual explanation to the people of this State. They are not offered as arguments to perpetuate a newspaper controversy.

This Committee consists of the following:

Drs. Joseph C. O'Connell, Morgan Cutts, Charles L. Farrell, Peter F. Harrington, Earl J. Mara, Clifton B. Leech, Morris Botvin, Harry Hecker, Joseph W. Reilly, Charles J. Ashworth and Peter Pineo Chase.

* * * *

A Rhode Island physician relaxing at home with his family received an emergency call on a Sunday afternoon. A child was desperately ill. A hurried trip to the patient's home followed. The diagnosis—poliomyelitis. How long has the child been ill? "He was sick last Tuesday afternoon, Doctor, but we put off calling you thinking he would get better. He got worse Friday, and today he has been very bad." "Why didn't you call a doctor when the illness started?" No answer.

It is 11:30 at night. The ringing telephone of a Providence physician halted him in his preparations for bed. "Doctor, my wife has a pain in her abdomen. Has had it for three days. Can you come right over and see her?" Three days in which to check the cause of the pain during the physician's normal working hours.

It was a Wednesday afternoon when the emergency call brought a physician to an elderly patient's bedside. "We have been unable to reach our family doctor, and we are thankful that you have come."

continued on page 514



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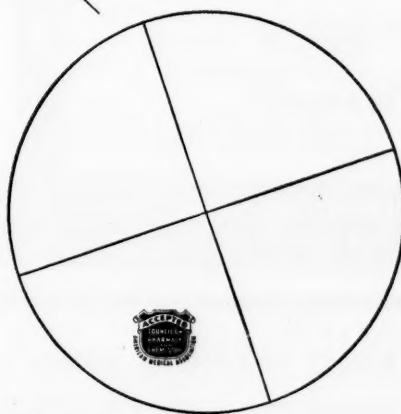
With prolonged *postoperative recovery*

Accompanying *prolonged pain*

When psychopathic problems develop *after childbirth*

Precipitated by *the menopause*

With debilitating or crippling *chronic organic disease*



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RHODE ISLAND MEDICINE

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The patient's illness — a heart attack, brought on by shoveling snow the hour previous. The family physician is later notified. His comment: "I have warned that man not to undertake any strenuous exercise or work because of his heart condition."

"Is the doctor in"?, the frantic telephone caller asks. "No, he is out on a call. Any message?" The receiver is dropped without further reply. The doctor's call: checking the condition of a drunken driver at the request of the police department in a city without an official police surgeon employed to answer all such calls. The result: a child injured in the neighborhood of the office of the physician is unattended until a physician from the other side of the city is reached and drives to the scene.

Nothing remarkable about these incidents to the physicians of Rhode Island. They happen regularly.

The remarkable thing is that in this compact, populous, and apparently well-informed and well-educated community some people suffer, and allow those about them to suffer anxiety, because they take good health for granted and do little to preserve it, because they ignore medical advice when it is given them, because they allow illnesses to develop to serious proportions before consulting a physician, because they apparently have little knowledge of the busy day of work for the average physician in general practice, and because they have become educated by press and radio advertising to try and cure all illnesses by self-medication.

Forget that the instances noted above are the so-called emergency cases. Multiply them by the hundreds of instances seen by physicians throughout the state and the country day in and day out in the regular course of their professional work. Instances of persons who disregard even the most common signals of pending ill health.


Instances of persons, who in spite of the nationwide campaign for years to detect symptoms of cancer, hide a growth knowingly and then seek medical attention late.

Instances of parents who, in spite of the warnings such as that of the superintendent of health in Providence two months ago to guard against the increasing incidence of diphtheria by having their children properly immunized, will fail to act.

Instances of persons with a chronic ailment, even of the heart, who disregard the admonition to 'take it easy' and as a result bring on a totally disabling illness.

Instances of persons who believe implicitly the claims of 'quacks', faddist, and cure-all remedies, offered with little or no scientific proof.

The list is endless, as any physician will testify.



The illustration shows a man in a tuxedo holding a tray with a glass of ginger ale. Above him is a large, ornate glass with the words "DRINK WARWICK CLUB" on it. The man is looking up at the glass.

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Every sickness and accident is an emergency requiring treatment. It is an emergency to the person incapacitated, and to his family. Such an attitude is perfectly normal, for we all know that we take good health for granted and any deviation from it is immediately disturbing mentally as well as physically.

But public opinion to the contrary, every sickness and accident is not a medical emergency requiring immediate attention by a physician.

In the course of any given day serious individual emergencies do arise that require medical attention, in some instance immediately. What the medical profession in Rhode Island has done, and is prepared to do regarding this type of emergency will be discussed tomorrow.

II

The *Evening Bulletin* in its articles on American Medicine stated that doctors as a group have failed to do anything about individual emergency medical service in Rhode Island, and about staggering their weekly days off.

But what are the facts locally?

As far back as 1943 the New England Telephone & Telegraph Company, and the Providence Police Department, were furnished lists of physicians who would be available for emergency medical calls in the Greater Providence area. Both agencies were asked to distribute the list throughout their subdivisions in order to provide night operators with a roster for calls requiring immediate attention. The physicians and surgeons telephone exchange was given the list also. In subsequent years lists numbering as many as 42 physicians for night emergency calls were checked for the telephone company.

In addition, since persons calling at night are alarmed and make separate calls for several physicians without informing each that others have been called, the following practical questions were suggested as helpful in checking the emergency calls: Who is your family doctor? Have you tried to reach him? If he can't come, has he referred you to any other doctor? Have you called anywhere else for a doctor? What result? What is the trouble — a cute illness or a chronic one?

What are the Emergencies?

To get some idea of the individual emergency night calls from 7 p.m. to 7 a.m., let's take for an example a tabulation for an eight month period by a large local physicians telephone exchange.

A total of 601 calls were reported. This is an average of 75 a month, or $2\frac{1}{2}$ a night, for a population of more than 250,000 persons.

Of these 601 calls 126 were not covered for the following significant reasons:

continued on next page

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51 persons, after discussing the problem, stated that they could wait until the morning to see their own family doctor.

31 persons were referred directly to hospitals.

15 decided, on reflection, that a doctor's visit would not be necessary after all.

14 wouldn't give any information.

15 were for alcoholics or drug addicts, or were cases requiring police investigation first.

Thus it is evident that the question of individual emergency night calls has not been neglected by the medical profession as a group. On the contrary, efforts are continually being made by the various district societies to guarantee that every real emergency is covered by a physician. The procedure adopted in Kent County was outlined by the President of the medical society there in a letter to the editor published in the *Providence Sunday Journal* of May 30. In Pawtucket a doctor's telephone exchange has been in operation for months and through it emergency calls are accepted.

The Providence Medical Association has been studying a plan for a central telephone exchange under the control of the Association for the physicians of greater Providence. This project will represent a sizeable cost. It will require a specially trained staff for 24-hour duty, and an office centrally located to warrant use of the exchange by doctors in all parts of the city. It will also seriously affect the present privately operated exchanges. These problems undoubtedly can and will be solved. The establishment of such an exchange will allow the Providence physicians to perfect a system under their own jurisdiction to cover all individual or group emergencies.

In providing this service the medical profession has a right to demand that it shall not be abused in any manner that can be prevented.

What about Doctors Free Days Off?

Much has been said of the difficulty in securing a doctor on a Wednesday. We question the difficulty of securing a physician on an afternoon, whether it is Wednesday or any other afternoon. The ma-

jority of physicians leave word at their home, or at a telephone exchange as to where they can be located if they are needed in an emergency.

A free afternoon or evening for the doctor, whether it is Wednesday or any other day, is merely a respite from his regular schedule of office hours. However, his telephone is covered by his home or a telephone exchange, and messages can be relayed to him even if he happens to be attending a hospital staff meeting, a medical meeting, or a performance at a theater.

Medical service is not limited by a work week, and Sunday is not the day of rest for the doctor that it is for most of the population. Hence, traditionally doctors have broken their week by taking Wednesday afternoon off. However, in recent years this situation has been altered, and every effort is being made to encourage members of the Rhode Island Medical Society to stagger their days off so as not to overload the men available for calls on Wednesday.

During the past year new members of the Rhode Island Medical Society have been asked to take other than Wednesday as a free afternoon.

Last November the House of Delegates, policy making body of the medical profession in Rhode Island, urged each district society in the State to develop a plan for the staggering of afternoons off by members of its society for the better protection of the public.

The Providence Medical Association, the largest district medical group in the Society, subsequently polled its membership asking for names of men who would shift their free day from Wednesday. The first results of that poll was published in the April issue of the *RHODE ISLAND MEDICAL JOURNAL*, which is available to anyone, when the names of physicians transferring their free afternoon were listed.

As another step towards aiding the public to know what day doctors are not available in their offices, the Rhode Island Medical Society has already planned when publishing its annual roster of members later in the summer to include a listing of the individual doctor's free day. This roster, as in the past, is available to any reputable agency prepared to use it in the interests of the public.

We believe that the public, once it is sufficiently informed of the problem, and is educated to procedures that should be considered when emergencies occur, will cooperate in the same manner in which it did during the war years when medical care was necessarily rationed. Certainly the carrying out of some of the following recommendations will contribute immeasurably to the improvement of the local situation.

1. Have a family doctor who will know you, be familiar with your health needs, and be pre-

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pared to assist you at all times. Even persons who are presumably well should undergo a physical examination at least once a year. Use this opportunity to establish contact with a doctor, possibly in your own neighborhood. Find out from your family doctor how you can reach him when you need him and whom you can call when he is not likely to be available.

2. If the ill person has a temperature, or serious pain in the afternoon, don't wait until late in the evening before calling the doctor. A person really sick early in the evening is likely to be the object of greater concern from the family in the still hours of the night. Get the doctor early, for his and the patient's sake.
3. The emergency that demands instant care is rare. Don't be unduly alarmed if you do not contact your doctor immediately. If the call cannot be relayed to him — and most calls can be relayed through the doctor's office, home, or telephone exchange — call the second doctor on your list.
4. If medical services are not available immediately in an extreme emergency, take the patient to a hospital, utilizing hospital ambulance or police car assistance if transportation cannot be provided otherwise.

III

Specialization is one of the characteristics of modern life. We have specialists in advertising; specialists in salesmanship; specialists in manufacturing; specialists in play, and specialists in almost any line of endeavor that might be mentioned.

Is it any wonder, then, that in medicine, a field in which knowledge has been advancing so rapidly that no one man can any longer keep pace with it, that there should be specialists?

The statement by the *Evening Bulletin* that "specialization is the triumph and the bane of American Medicine" is contradictory.

Specialization has been a natural development in medicine. It has not been created as a means of bettering the lot of certain doctors. Its sole purpose is to provide better medical and surgical care to the public. Everyone has become increasingly conscious of the extent to which modern scientific research has broken barriers to the previously unknown facts in disease control and prevention. The public continues to expect steady improvement in the protection and preservation of life to the point where it now demands a greater and more specialized quality of medical care.

What has been medicine's problem resulting from this demand?

It is twofold: how to continue to provide the best medical care in the face of increased demands

upon such specialized knowledge, and how to hold down an unavoidable cost factor in the supplying of the specialized service.

The pressure of both these complex factors offers a threat of making medical practice spread itself so thin that quality everywhere may be lowered. So far such deterioration has been avoided through specialization.

The creation of the Specialty Boards is one way by which medicine has sought to assure the public that the physician holding himself forth as a specialist in a definite phase of the healing art is qualified. The purpose of these Boards, of which there are but 15, is to direct the training of young doctors by requiring them to complete a minimum course of advanced study in addition to medical school and hospital intern training. This advanced study for specialty rating may require up to five years; usually a minimum of three years.

Even after completing his studies the doctor is not automatically entitled to specialty rating. He must first pass an examination given by the Board for the particular specialty in which he wishes to practice exclusively, such as anesthesia, obstetrics, pediatrics, surgery, eye, ear, nose and throat, etc.

How Many Specialists Are There?

The *Evening Bulletin* has stated in its articles that "there are today nearly 60 specialty societies,"
continued on next page

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and close to 50,000 American physicians who call themselves specialists."

The Committee on Public Policy of the Rhode Island Medical Society corrects this statement.

First, there are only 15 Specialty Boards certifying physicians for specialty rating. There are in addition many state, regional and national societies of specialists which exist purely for educational purposes, but such societies have nothing to do with qualifying men or women as to specialty rating in medicine.

Secondly, statistics show that in 1947 there were but 28,476 physicians certified by the specialty boards — less than one-seventh of the total number of physicians in the country.

The Role of the General Practitioner

The increase in specialty work does not mean that the general medical practitioner is not as he always has been — the very backbone of medicine. He, too, has been benefited by the tide of specialization, and he is a part of it, and not apart from it.

Consider the great difference between the educational training of the family doctor of today and his predecessor. Medical education has been growing, courses of study have been extended, and years of internship training have been added. This background, coupled with his own experience and observation in the hospital, the bedside, and the office

make him the physician of first choice for every family.

Contrary to the opinions expressed by the *Evening Bulletin* medical schools have for years educated men well to be primarily general practitioners. There is even one school in New England — The Tufts College Medical School — which emphasizes the training of family doctors.

The struggle on the part of medicine to achieve an ideal solution for the problems that face it in meeting the demand for both specialty and general medical care should not be made greater by confusing the issue.

The criticism that the specialist is unavailable in an emergency, especially at night, is unwarranted. Whether he is the surgeon, the anesthetist, the eye specialist, the obstetrician, the radiologist, or any other, the specialist is available for emergencies within his field of concentrated work. You will find him answering the call to duty in time of emergency, whatever the day or hour.

Nothing can suppress the trend toward specialization which has been a natural outcome of increased medical knowledge and techniques designed for the protection and preservation of health. Doctors are aware of the need for changes in the distribution of medical care. However, no immediate increase in either educational facilities or the

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number of applicants for medicine is possible. Present studies indicate that long term planning can and will accomplish this end without interfering in any way with the present high level of medical efficiency.

The writer of the *Evening Bulletin* articles on American Medicine thinks that the solution of the entire problem lies in "high quality group practice." What he fails to realize is that there are certain fundamentals governing the practice of medicine of which we should never lose sight. Foremost is the indisputable fact that medicine is an art and not an exact science, no matter what radical advances are made in science.

This will necessarily be so because there is an art in establishing prompt obedience to directions; in obtaining the wholehearted cooperation of a patient; in imparting and in having adopted useful information and instructions; in winning the confidence of frightened children; in understanding comprehensively the discouraging problems of the aged while sympathetically ministering to them; in entering strange homes and inspiring confidence in one's ability to cope successfully with any illness that has occurred. The art reaches its height in comforting as well as prescribing.

It was the practitioner of the art, and not the scientific laboratory, who discovered vaccination,

who first ventured to use ether for a surgical operation, who introduced digitalis in the treatment of heart disease and who discovered insulin for diabetes.

IV

In discussing the costs of medical care the *Evening Bulletin* stated that "most of the millions of Americans who do not receive adequate care fail to get it for the simple reason that they cannot pay for it."

Generalizations such as the one above can be made about housing, nutrition, education, sanitation, or any other phase of better living.

What is adequate medical care? As implied by the *Evening Bulletin* it is the utilization of every available medical and allied health service regularly for every person, even to the extent of "x-rays, blood chemistry, a gall bladder series, kidney and liver function tests, metabolic rate tests, and others that modern medicine has devised."

The author of the articles on American Medicine suggests that every one of the millions of persons in this country requires all such medical services annually, or oftener, and he assumes that these procedures are routine for "adequate" and "decent" medical care.

continued on next page

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No physician believes that. We hope that few persons accept any such viewpoint.

Why? Because adequate medical care cannot be generalized. It is an entirely different problem with each patient. For one person certain tests may be imperative to aid in determining the existence of an organic disability. For another person there may be no indication prompting the physician to conduct laboratory tests. A third person may refuse to accept the diagnosis of his physician as final and request additional laboratory tests regardless of expense.

But for the patient to request, or for the physician to give, all, or the majority of the tests when there is no indication for them in the routine physical check-up is merely to increase the cost of medical care unnecessarily. An annual physical examination by the family physician is not beyond the economic reach of anyone. For the majority of the population the cost would be no more than the prevailing fee for a regular visit to a physician's office.

Cost Factors

Professional fees for medical care have varied little through the years and have not increased in proportion to the rise in the general cost of living. Yet the physician is faced with increased expenses in rendering services to his patients. There is no ceiling on the cost of the supplies, equipment and personnel he must utilize. For example, bandages which cost \$6 a gross a year ago, now cost \$24. X-ray films, instruments, and other supplies have increased in cost. Likewise, salaries for office nurses, secretaries and technicians have been raised.

Criticism has been made of physicians' prescriptions for medicines. Most often the specially trademarked product is superior to the minimum required by the pharmaceutical standards. A prescription from the physician is an *order* to the pharmacist who is a professionally trained man skilled in compounding drugs. The pharmacist has the responsibility of certifying the accuracy, the potency, and the safety of the preparation.

The person who buys the twenty cent box of laxatives takes all the responsibility for the use of his purchase. There is no guarantee as to the dosage, quality, purity, freshness — other than as stated on the package label — or as to whether it is the proper medication for the particular ailment for which it is purchased.

Good drugs properly compounded are just as wonderful in their own action as the "wonder" drugs of penicillin and sulfa, and their cost is proportionate, not excessive.

Are Specialists Fees Excessive?

Modern procedures and techniques in health care and health preservation, new drugs processed at

great expense, increased use of hospitalization services — all contribute to the cure and control of disease. All claim their sizeable proportion of the overall cost of rendering medical care to the individual patient. These factors must be borne clearly in mind when appraising the fee for the physician's services. The specialist's fee is naturally somewhat higher because of his restricted practice and his more lengthy training.

The *Evening Bulletin* has stated that some specialists give a patient a "run around". It illustrated its case by stating that the patient "goes to a heart man and is sent to a stomach man, who looks him over and bounces him on to the lung expert (and) in each case he pays a substantial fee."

Occasionally there is a patient who requires the service of several specialists for complete diagnosis and treatment, but such referrals are made only with the patient's welfare in mind.

Specialization has resulted in part from public demand for highly-skilled services in restricted phases of healing.

Writers for newspapers and magazines have often over publicized in sensational manner medical and surgical techniques still in the process of development. As a result many a patient is misled into by-passing his family physician and heading directly to the specialist's office — with definite ideas of his own regarding his sickness and treatment.

Too often the patient incurs, on his own, expenses for services for which he has no need. A visit to his family doctor, who in turn is prepared to refer him to the proper specialist if special service is necessary, would often be more economical.

Free Medical Service

The medical profession of Rhode Island has never failed in its obligation to render medical care to the people of this state. To our knowledge no person in Rhode Island, regardless of his financial status, has been denied care.

There is no stigma attached to any free medical service rendered privately or in the hospitals of this state. That free medical service of tremendous cash value is given is shown by the record of Rhode Island Hospital for 1947.

Let's look at this record. Remember that each outpatient department visit is equivalent to an office call and the modest charge of \$2 is used; that each ward patient was seen by at least one visiting staff man daily, and therefore the patient days charged at \$2 gives a minimal value on this time by the visiting staff; and that for the final value 60% of the ward admissions in surgery at an average fee of \$50 per surgical operation was used.

Look at the total of free care by the Rhode Island Hospital staff alone—

Outpatient department visits	54,728 @ 2.00	\$109,456.00
Ward patient days	95,679 @ 2.00	191,358.00
Surgical ward care	3,703 @ 50.00	185,150.00
Total		\$485,964.00

Multiply this contribution proportionately for all the other hospitals in Rhode Island, and America, and you gain some idea of the free public service rendered by the medical profession.

V

Did you know that insurance for surgical operations in Rhode Island will be available to employed groups of twenty-five or more through their employer on a cost-sharing basis under which the employee would contribute only 10 cents a week for himself, or 35 cents a week for himself and his family, under one of the policies approved by the Rhode Island Medical Society for its new surgical insurance program?

Did you know that another policy to be offered under the plan will be available to groups of five or more employed persons at 75 cents a month for an individual, and \$2.50 a month for an entire family, and if additional protection is wanted for medical expense when a person is hospital confined and no surgery is performed, it can be bought for only

\$1 a month for an entire family, including man, wife and children?

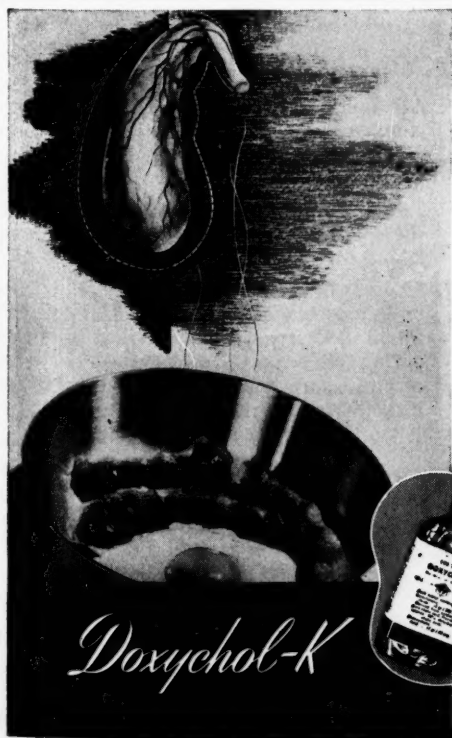
The *Evening Bulletin*, in discussing voluntary prepaid insurance plans in its series on American Medicine quoted "expert observers outside the State" relative to the Rhode Island surgical plan to the effect that "its premiums are higher than they would need to be under a non-commercial setup."

We are certain that these "experts" did not have detailed information of the Rhode Island Surgical Plan.

There is no significance to the fact that Associated Medical Care Plans has not approved the Rhode Island Plan. That organization only passes on programs that are *exclusively* non-profit in their setup. The Rhode Island Plan is not even eligible for consideration as it includes both non-profit and profit organizations. Since the members of the Rhode Island Medical Society have endorsed the local plan, approvals by other organizations will add little.

The Rhode Island Medical Society has clearly stated that it will welcome Blue Cross as an insuring agent on the same basis as the Metropolitan Life Insurance Company, the John Hancock Mutual Life, the Equitable Assurance Company, and all the other insurance organizations supporting its program. There is no lack of cooperation upon the

continued on next page



"The General Practitioner Can Relieve 3 out of 4"

One acute researcher has noted that the odor of frying bacon causes emptying of the gallbladder in some subjects.

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That's what happens when we as a people commit ourselves to a single plan, whether it is administered by government or a private monopoly.

That's why the Rhode Island Medical Society has come forward with its new prepaid voluntary surgical plan which is now being copied in several other states in the country. We want every insurance agency, whether it is profit making, or non-profit-making—and of the seven largest companies active in group health insurance in this country *five* are mutual companies which under the law cannot make a profit—to compete so that the people of this state will have a choice of plans.

We all know that competition in business is the major factor in keeping costs down, and in providing the purchaser with more attractive products.

Here is a summary of some of the highlights of this Rhode Island Plan:

1. Thirteen large insurance companies—including the Metropolitan Life—are actively backing the plan.
2. Competition will provide the lowest premium rates for any surgical insurance plan sponsored by any medical society in the country.
3. Employed groups as low as five can be enrolled under some of the policies. Very few plans in the country have accepted such low group enrollment.
4. Dependents of employed workers may also be enrolled.
5. Immediate coverage is provided for both the individual and his dependents.



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RHODE ISLAND MEDICAL JOURNAL

6. The number of operations that can be performed in any one benefit year is not restricted.
7. All types of surgical care—from a boil, a foreign body in the eye, a cut requiring stitching, to the most extensive major surgery—is provided.
8. The surgery may be done in the hospital, the doctor's office, or the patient's home.
9. For the person without dependents earning less than \$2,000 a year, and for the person with dependents earning less than \$3,000 a year, the policy payment covers the complete surgical cost. For persons above these incomes the policy provides cash payments ranging from \$5 to \$150, according to the operation, towards the physician's fee.
10. Every policy holder gets additional liberal payments towards the cost of anesthesia, blood or plasma transfusions, and for the services of an assisting physician.
11. Approximately 600 Rhode Island physicians have agreed to support the plan, and to accept the insurance payment as full fee for persons in the income groups.
12. The policy holder is protected under most policies for a limited period following the expiration of his insurance coverage.
13. There are no waiting periods, such as exist in plans in most states, for surgical operations on tonsils, adenoids, hernias, hemorrhoids, etc.
14. Provision is available under some policies for immediate coverage for obstetrics.
15. All non-occupational injuries for which compensation is not paid under the workmen's compensation law are covered.
16. Every policy is approved by the State Insurance Commissioner, and must also meet the specifications established by the Rhode Island Medical Society.
17. There is free choice of physician. However, only those members of the Rhode Island Medical Society who have signed as participating physicians are obligated to accept the insurance fee as complete payment for those persons in the income groups.

If there is a medical society sponsored insurance plan in America that offers more than this to its subscribers, and at costs comparable to those being set by the various companies underwriting the Rhode Island Plan, we have yet to see or hear of it.

What About the Above \$3,000 Group?

The \$3,000 family income limit for the service feature of the plan is the one generally accepted throughout the country by all the non-profit plans. Until experience in Rhode Island determines otherwise, our plan is employing that limit. How will it

work out for the person with dependents whose family income is above \$3,000?

Suppose, for example, Joe Doe makes \$3,500 a year. He is married and has three children. He has an acute attack of appendicitis, is hospitalized and operated upon. If he has Blue Cross insurance he gets \$7 a day towards his hospital bill, but he pays any additional charge for semi-private or private room accommodations, and for x-rays.

If he has an insurance policy under the Rhode Island Plan he gets for this operation

- (1) an allowance of \$20 towards the fee for the anesthesia given by a physician
- (2) an allowance of \$15 towards the expense of a surgical assistant
- (3) an allowance of \$100 towards the surgeon's fee.

Let's suppose the complete charges for the services of the physicians are \$185. Joe Doe gets \$135 from his insurance company and he has the balance of \$50 to pay himself. That isn't a sizeable amount, but it might be under unusual circumstances, if, for example, Joe Doe has had a recent death in his family, financial reverses in business, or illness of his children. He can still discuss the problem with his physician as he does now.

Suppose Bill Smith whose income is in excess of \$3,000 honestly believes that he has been charged

an excessive fee for an operation? What can he do about it?

If such a situation arises, Bill Smith can take his problem directly to the medical profession, for the Rhode Island Medical Society has set up a Health Insurance Committee of physicians which, among other things, will act upon any complaints of persons insured under the plan.

The Rhode Island Plan is a good Plan. The doctors believe they and the insurance industry of this country can make it a successful contribution to the social security of the people of this state.

VI

Rhode Island doctors, as well as doctors throughout the country, are opposed to governmental control of the practice of medicine.

Doctors are not afraid of "socialized medicine." On the contrary they have done more to socialize medicine than has any other group.

Consider medicine's part in public health work—city, state and national. Here in Rhode Island the doctors of Providence fought for a city health department nearly a hundred years ago. They have continued such leadership ever since in promoting health care. Consider what doctors have done in municipal and state hospitals, like our Chapin Hospital, the institutions at Howard, and Wallum Lake. Doctors have socialized school health programs,

continued on next page

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service to welfare departments, industrial programs, and many others.

The term "socialized medicine" is often used to obscure an issue. Doctors have misused the term themselves when they were actually referring to federal or political control of medical practice.

Let's be clearly understood, then. Doctors in Rhode Island are not only opposed to political control of medicine, but we will resist it because it represents a system that not only will not, but cannot, live up to the glittering promises made by its proponents; because it represents centralized bureaucratic control at its worst; because it would be far more costly to the people of this state, and every other state, than the present system; because it would contribute little or nothing to improve health; and because it would lower the quality of medical care which, on the other hand, doctors continually seek to better.

Not Alone in Fight

The proponents of universal federally-controlled health service through payroll taxation claim that some Americans in some parts of the country who now get little or no medical attention would get some under their plan. But even the people in the rural areas of America, who presumably are faced with the major problem in the whole picture of medical care, are opposed to the idea of federal control.

Hear what the American Farm Bureau Federation representing 1,250,000 farm families said at its last annual meeting in opposing compulsory government health insurance:

"We are opposed to legislation designed to provide compulsory medical, health, dental, and hospital insurance. We recommend the full co-operation of rural people with our established health units and existing health programs. We believe the voluntary organizations of cooperative health associations will encourage people in need to take advantage of the services available for any medical or dental care which they may require."

Not Insurance

The American people know what private insurance is, whether it is insurance on their life, health, home, or auto. If they don't like what one policy offers they can cancel it for another. The compulsory national health proposals are not that kind of insurance, if they are insurance at all.

The proponents for the nationalization of medicine, under such acts as the one proposed by Senators Wagner and McGrath, seek to create the impression that it would provide just a form of protection similar to life or hospital insurance, or any of the other kinds with which we are familiar. It would not.

It is a plan for Government administration of all

medical care supported by a tax on payrolls and a Federal subsidy from taxes to cover the deficits. This is taxation and not insurance. It deprives the employee of his freedom of choice in spending the money he earns.

Staggering Costs Inevitable

What would it cost to carry out such a plan?

To operate the machinery required for a compulsory national health plan would take anywhere from 250,000 to 1,500,000 employees, in addition to the medical profession, and would involve tremendous political patronage. More than fifty million cases would have to be checked every year as a basis for payment and for statistical information. It is well-known that federal bureaus of this nature are notoriously inefficient and expensive.

The Wagner-McGrath compulsory health plan would claim 3 per cent of all earnings up to \$3,600 a year, and additional appropriations equal to 1 per cent of taxable payroll. Add to that the 2 per cent now going into old age and survivors insurance, and the 1.8 per cent on an average that is paid for unemployment compensation. And in Rhode Island add in the 1½ per cent of all earnings up to \$3,000 for the cash sickness act. This is the beginning; the end of the taxing isn't in sight.

Since it would be inexpedient to have either the worker or the employer bear the whole cost, the political planners would provide for a cost-sharing arrangement. Thus, from the outset a large and increasing sum would have to be paid by every tax payer already burdened with the costs of federal, state and municipal governments.

No Aid to Health Improvement

There isn't a bit of evidence presented to date to show that an overall tax plan for medical care would either give anyone more medical care than he is now receiving or at a less cost. Other countries with such programs have had no decline in sickness; on the contrary a steady increase both in the amount and length of recorded disability. Costs in such plans have mounted steadily and the quality of medical care has tended to deteriorate, for the incentive is soon lost by the physician who is no longer a free agent.

Compulsory schemes abroad are no models for America to follow. We have all seen in recent years evidences of the weakening of the freedom of the individuals in other lands because of the excessive dependence on government to solve their personal problems.

Reports of Experts

Two recent outstanding reports by experts in health and welfare contain conclusions that warrant repeating.

The National Health Assembly held a month ago in Washington point out that

"A medical care program itself will not solve the health problems of the nation. It must be coordinated with all efforts directed towards providing the people with adequate housing, a living wage, continuous productive and creative employment under safe working conditions, satisfying recreation and such other measures as will correct conditions that adversely affect the physical, mental and social health of the people."

The Brookings Institution, one of the country's best known and most reliable institutions in the field of social, economic and governmental research, invited by a Congressional committee to prepare a memorandum on medical care for the individual, stated among its conclusions that

"It is apparent that the United States under its voluntary system of medical care has made greater progress in the application of medical and sanitary science than any other country. This progress is now reflected in low mortality and morbidity rates of infectious diseases and in increased life expectancy. There is every reason to believe that these trends will continue unabated under our present system of medical care."

"The advances in health among both the whites and the non-whites that have been made in the United States in the past four decades do not suggest basic defects in the American system."

"The United States has some individuals and families not possessed of the resources to enable them to pay for adequate medical care. In the future, as in the past, provision must be made for them through public funds or philanthropy. The evidence suggests that many of them are elderly, impaired, or underendowed or are widows or deserted women or their dependents. It is doubtful if they could be effectively covered by compulsory insurance because they would lack the means to attain and maintain an insured status. The large majority of American families have the resources to pay for adequate medical care if they elect to give it a high priority among the several objects of expenditure. The issue is not whether they can afford medical care but whether they should be compelled by law to pool their risks and to give payment for medical care a top priority. The major alternative for people with ability to pay is to leave them free to determine for themselves what medical care they desire and whether they will pool their risks through voluntary arrangements."

VII

The world owes no one good health anymore than it owes him a living. One as well as the other depends on personal attention to individual welfare and is subject to the same variations.

As Dr. E. V. Askey, president of the California Medical Association, pointed out to the national conference of school and health educators last

October, "the public should be educated to expect some amount of illness as a normal outlook, rather than to expect that good health is normal and that illness is something unusual."

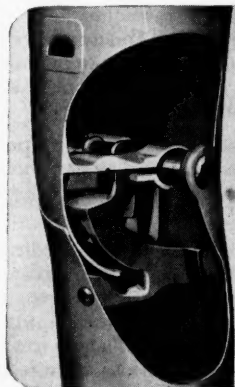
The struggle for a healthy existence starts at birth. For some persons illness and disability are immediate; for nearly all they are inevitable sometime during life.

Medical care is but a part of the entire problem of health care. The United States Social Security Board pointed this fact out clearly, stating that "Health among a people depends on many factors other than medical care — among them, the amount and distribution of national income, the level of education and of sanitary safe guards, and climate and other environmental factors."

Doctors know how seriously good health is influenced by these factors. That is why they have always been active in campaigns to protect and preserve good health. Preventive medicine is only a new wording for what doctors have always preached and practiced.

From the days 60 years ago, when Dr. Charles V. Chapin urged improvements in hygiene and sanitation, citing problems involved in heating and ventilation of buildings, garbage disposal, filtra-

continued on next page



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tion of water, and disinfection techniques, to the present when doctors seek water pollution control, smoke abatement, and sanitary regulations for restaurants, the medical profession has led in fields of preventive medicine and health.

Personal Health Rules

Every person is the guardian of his own good health. The adoption of recommendations such as follow will help both the patient and the doctor to maintain and restore good health:

1. Don't wait for a serious illness before you ask your doctor's help. The earlier he sees you, the more he can do to help you avoid a major illness.
2. Have a family doctor who will know you, be familiar with your health needs, and be prepared to assist you at all times. Even persons who are presumably well should undergo a physical examination at least once a year. Use this opportunity to establish contact with a doctor, possibly in your own neighborhood. Find out from your family doctor how you can reach him when you need him and whom you can call when he is not likely to be available.
3. Tell your doctor the complete facts. A previous illness may not seem to you to have any bearing on your present condition, but to your doctor it might be a valuable clue.
4. If your doctor prescribes medicine, take it according to his directions. And remember not to use medicine prescribed for somebody else; your illness may be quite different however similar the symptoms seem to you.
5. If your doctor advises an operation, don't put it off. With modern surgery and modern hospital care, you seldom have reason to fear an operation.
6. The doctor knows all about new medical treatments through his own journals and scientific meetings, and they are not news to him when they are discussed in the popular press. If he does not recommend a new treatment for you it is probably because there is still some question of its value, some limitations not mentioned in the popular reports, or some reasons in your case which would make the treatment undesirable or ineffective.

The Cost Factor

Medical care is expensive, and it is becoming more expensive. But medical care is more than the services of the physician, it represents hospital costs, drugs and sundries, services of the dentist, and services of laboratories and persons skilled in special techniques. Each of these factors in turn is interwoven with the general economic pattern of the day. Thus, the rising cost of wages, supplies,

food, equipment, etc., has its corresponding affect upon the cost of hospitalization, the physicians' services, and so on down the line.

What are doctors doing to assist in the distribution of the cost for their services?

For one thing, doctors have not raised their fees in proportion to the general increase in the cost of living. For another, they have worked out in most states, as we have in Rhode Island, a plan to provide for the prepayment of surgical operations by low cost insurance. Doctors have met the challenge of the times to provide the means for a voluntary solution of economic problems involving major medical costs; upon the public rests the responsibility to support the voluntary method of prepaid insurance, or relinquish its freedom in choosing its medical and other services to the federal government.

Rhode Island and the A M A

The *Evening Bulletin* has made reference to the control of the American Medical Association over the Rhode Island physicians. We correct this misunderstanding. The Rhode Island physician belongs first to his district or county medical society through which he has affiliation with his State medical society. All members of the Rhode Island Medical Society are automatically members of the American Medical Association.

The national association no more controls the Rhode Island Medical Society than the Federal government does the State of Rhode Island. The medical profession of this state act as they deem best for the people of this state, and never have they been restrained in any of their activities by the American Medical Association.

An outstanding example of this freedom of action is evidenced in the Rhode Island Plan—the prepaid voluntary surgical plan of the local doctors. This program, a new approach in that it utilizes both profit and non-profit insurance groups, cannot be controlled nor influenced in any manner by the American Medical Association, whether or not that Association likes the plan.

Facing the Future

We believe that the American people should build on the foundation of our present accomplishments. Our present plans for promoting health care have developed to the point that if expanded carefully and energetically they can provide much of the framework for the better national health which the American people seek and which they have a right to expect.

Real progress, however, requires more than technical knowledge and money. It requires resourcefulness and ability to work with initiative and determination. There is no easier way, though some persons think various forms of federalization

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RHODE ISLAND MEDICINE

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offer a short cut. For all of us, physician and patient, there is a responsibility if we are to achieve better health, in Rhode Island as well as nationally.

* * * *

The Committee on Public Policy of the Rhode Island Medical Society appreciates the opportunity accorded it by the *Evening Bulletin* to express the doctors' views on problems involving medical care in this state. It has presented its story in an effort to explain, and not to provoke any argument or controversy.

For the Society, the Committee expresses the request that any person in Rhode Island who may ever be denied attention by a physician report the incident with full facts to the Committee on Public Policy, The Rhode Island Medical Society, 106 Francis Street, Providence 3.

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Committee Appointments For 1948-1949

Mrs. J. Murray Beardsley, President of the Woman's Auxiliary, announces the following committee appointments:

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Mrs. Bertram H. Buxton	Providence
Mrs. James C. Callahan	Newport
Mrs. Louis C. Cerrito	Westerly
Mrs. H. Lorenzo Emidy	Woonsocket
Mrs. Hubert Holdsworth	Bristol
Mrs. Edwin F. Lovering	Pawtucket
Mrs. William H. Tully, Jr.	Wakefield

Program Committee

Mrs. Joseph C. Johnston, <i>Chairman</i>	Providence
Mrs. J. Merrill Gibson	Providence
Mrs. J. Lincoln Turner	Pawtucket
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 O'Donel T. D. Browne—*The Rotunda Hospital, 1745-1945*. Balt., 1947.
 George Crile. *An Autobiography*. Edited, with Sidelights, by Grace Crile. 2 vols. Phil., 1947.
 Bernard J. Ficarra—*Essays on Historical Medicine*. N. Y., 1948.
 John B. Wheeler—*Memoirs of a Small-town Surgeon*. N. Y., 1935.

GORMLY COLLECTION

- Thomas A. Gonzales et al—*Legal Medicine and Toxicology*. N. Y., 1940.

ALLERGY

- Warren T. Vaughan—*Primer of Allergy*. 2nd ed. St. L., 1943.

ANESTHESIA

- Stuart C. Cullen—*Anesthesia in General Practice*. Chic., 1946.
 Chauncey D. Leake—*Letheon. The Cadenced Story of Anesthesia*. Austin, 1947.
 J. H. Walton, editor—*Control of Pain with Saddle Block and Higher Spinal Anesthesia*. Summit, 1948.

CARDIOLOGY

- George E. Burch & Paul Reaser—*A Primer of Cardiology*. Phil., 1947.
 Emanuel Goldberger—*Unipolar Lead Electrocardiography*. Phil., 1947.

CHEST

- Eli H. Rubin—*Diseases of the Chest. With Emphasis on X-ray Diagnosis*. Phil., 1947.

DERMATOLOGY

- Kurt Wiener—*Skin Manifestations of Internal Disorders (Dermadromes)*. St. L., 1947.

ENDOCRINOLOGY

- Willard O. Thompson & Tom D. Spies—*The 1947 Year Book of Endocrinology, Metabolism and Nutrition*. Chic., 1948.

GERIATRICS

- Wingate M. Johnson—*The Years After Fifty*. N. Y., 1947.

HISTORY OF MEDICINE

- History of the Medical Society of the County of Westchester, 1797-1947*.

HEMATOLOGY

- Joseph M. Hill & William Dameshek—*The Rh Factor in the Clinic and the Laboratory*. N. Y., 1948.

MEDICINE

- Russell L. Cecil, editor—*A Textbook of Medicine*. 7th ed. Phil., 1947.
 George F. Dick et al, editors—*The 1947 Year Book of General Medicine*. Chic., 1947.
 Robert P. McCombs—*Internal Medicine in General Practice*. 2nd ed. Phil., 1947.
Modern Medicine Annual—1947. Minneapolis, 1947.

MILITARY MEDICINE

- Edwin C. Andrus et al, editors—*Advances in Military Medicine*. 2 vols. Bost., 1948.
 DeWitt Mackenzie—*Men Without Guns*. Phil., 1945.

NEUROLOGY AND PSYCHIATRY

- Edmund Bergler—*The Battle of the Conscience*. Wash., 1948.
 Charles S. Bluemel—*War, Politics and Insanity*. Denver, 1948.
 Louis S. London—*Libido and Delusion*. 2nd ed. Wash., 1945.
 Israel S. Wechsler—*A Textbook of Clinical Neurology*. 6th ed. Phil., 1947.

OCCUPATIONAL MEDICINE

- Health of Arc Welders in Steel Ship Construction*. Public Health Bulletin No. 298. Wash., 1947.

OPHTHALMOLOGY

- Ralph G. Hurlin et al—*Causes of Blindness Among Recipients of Aid to the Blind*. Wash., 1947.

OTORHINOLARYNGOLOGY

- William L. Ballenger et al—*Diseases of the Nose, Throat and Ear*. 9th ed. Phil., 1947.

PATHOLOGY

William Boyd—*A Text-Book of Pathology*. 5th ed. Phil., 1947.

PHARMACOLOGY

Walter A. Bastedo—*Pharmacology, Therapeutics and Prescription Writing*. 5th ed. Phil., 1947.

PHYSICIAN-PATIENT RELATIONSHIP

Benjamin F. Miller—*You and Your Doctor*. N. Y., 1948.

Henry B. Richardson—*Patients Have Families*. N. Y., 1945.

POLIOMYELITIS

Collected Reprints of the Grantees of the National Foundation for Infantile Paralysis, vol. VII, 1946. N. Y., 1947.

RADIOLOGY

Charles A. Waters & Ira I. Kaplan, editors—*The 1947 Year Book of Radiology*. Chic., 1947.

SEX

Alfred C. Kinsey et al—*Sexual Behavior in the Human Male*. Phil., 1948.

SURGERY

Frederick Christopher—*Minor Surgery*. 6th ed. Phil., 1948.

Evarts A. Graham, editor—*The 1947 Year Book of General Surgery*. Chic., 1947.

TRANSACTIONS, REPORTS, etc.

Transactions of the American Association of Genito-Urinary Surgeons, vol. XXXVIII, 1946.

Transactions of the Association of American Physicians, vol. LX, 1947.

Transactions of the American Therapeutic Society, vols. XLV & XLVI, 1945-46.

Life Insurance Medical Research Fund, 3rd Annual Report, 1947.

Baruch Committee on Physical Medicine, Annual Report for April 1, 1945-December 31, 1946.

University of Pennsylvania. 31st report of the Henry Phipps Institute, 1944-1946.

Handbook and Directory of the State Medical Association of Texas. 1948.

Index to Current Periodical Literature On Neoplastic Diseases, July-December 1947. Gift of the Louisiana State Division of the American Cancer Society.

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BOOK REVIEW

WAR POLITICS AND INSANITY. By C. S. Bluemel, M.D. *The World Press, Inc.*, Denver, Colorado, 1948.

This book, written by a psychiatrist, has as its purpose, as the author states, the study of the "psychological qualities of political leadership and to identify the disorders of personality with which aggressive leadership is commonly associated". It is written for the layman in simple fashion in language that is understandable, in eleven brief chapters, 117 pages long.

The author discusses such topics as the causes of war, problems of leadership, and the psychodynamics of pathological leaders. He attempts to show analogy between human and animal leadership. He discusses the obsessive compulsive traits. He has a chapter on Psychiatry and History and a final chapter on The Future of Democracy, in which he outlines an idea for the more efficient management of democracy. Dr. Bluemel's analysis is not only on a very superficial basis but his use of psychiatric terminology is rather loose. He uses the term—obsessive compulsive trait—in a fashion that would signify both an abnormal and a normal characteristic. This is contrary to what is commonly accepted, for they are definitely pathological entities. He characterizes the accomplishments of people like Columbus, Peary, Florence Nightingale, Henry Ford, and many others, as possibly due to an obsessive compulsive trait.

The author feels that much of the difficulties in the world today are due to poor leadership, but he fails to explain how such men became leaders and he loses sight of the forces which produce this pathological type of leadership.

The plan that Dr. Bluemel promulgates for the improvement of democracy he describes as a "scientific one". In it he would allow only those of us who have a university education the privilege of voting and then only some twenty years after the university education had been completed. Need I point out that had we had such a plan our country would have been deprived of some of its greatest leaders. Furthermore, such a system would give us leaders who would represent only one group of people. They would have no knowledge or comprehension of the needs of a great segment of our population nor would they have the incentive to improve their lot. Virtually, it would lead to slavery of the disenfranchised. The author suggests that the plan is original. However, the writer feels that Plato outlined a very similar one some two thousand years ago.

DAVID J. FISH, M.D.

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